SERVICE AGREEMENT

Client: _____ Responsible Person: _____

Address: _____ Address: _____

City: _____State: ___ Zip: _____ City: _____State: ___ Zip: _____

Home Phone: _____ Cell: _____ Home Phone: _____ Cell: _____

Service Invoices will be addressed to: (Address City, State, Zip, Code)

_____

and emailed to: _____

Desires to enter into Service Agreement with Central Florida Care Group, Inc. Providing services listed on the attached Plan of Care (POC).

RATES, FEES & DEPOSITES. The services will be provided at the following rates.

Hourly rate $_____

Live-In $_____

24-Hrs $ _____

Other $ _____

Deposit $ _____ (based on payment option)

The minimum shift length is 2 hours/day. Weekends begin at 7pm on Friday and end at 7am Monday morning. Holidays are billed at "time-and-a-half". Designated holidays are New Year's Day, Memorial Day, July Fourth, Labor Day, Thanksgiving, and Christmas Day. Live-in rate noted below assume that the caregiver's food comes from the family pantry. An additional charge of $15 per day If caregiver must supply his/her own food

RATES

Starting at:

$ 18 - per hour. (minimum 4hrs/day)

$ 22 - per hour. (> 4hrs min 2hrs/day)

$ 260 - per day (Live-In)

$ 432 - 24-hours Care (contingent upon service rendered)

$ _____ Other: _____

$ _____ Other: _____

SERVICE AGREEMENT

Starting Date of Services:

From: ____/____/_____ To: ____/____/_____

Rates are subjected to change upon 7 days of notice depending on the actual level of care and services required, as assessed by the actual Caregiver.

PAYMENT

Payment options:

____ **Bi-Weekly Payment;** The payment is due every other Friday in the month, based on the service start date.

____ **Weekly Payments:** The payment is once per week.

Please Mail your Checks and Money Orders to:
247 Grouper Ct.
Poinciana, FL 34759
OR

Payments can also be made online at https://www.cfcaregroup.com/terms-of-payment

RESTRICTIVE COVENANT. I agree not to do business directly with any caregiver or individual that Central Florida Care Group Inc has introduced to me or by employing such caregiver or individual. I also understand if I violate this 'Covenant' I will be fined $5000 that will be due and payable to **Central Florida Care Group, Inc.** (_____).
Initial.

By signing this agreement, you agree to all terms a condition within this agreement.

Client/Responsible Party

Print Name: _____

Signature: _____ Date: ____/_____/_____

Central Florida Care Group Inc.
Official
Print Name: _____

Signature: _____ Date: ____/_____/_____