Member (Employer): ____

Phone: (   )_______________ Cell: (   )_________________ Other: (   )________________

Address: ____

City: ____________________________________ Sate: _____________ Zip: _________________

Person in charge (ie: member or a representative): _______________________ (   )_____________

Independent Caregiver (Employee): ____

Phone: (   )_________________ Cell: (   )____________________

Address: ____

City: ____________________________________ Sate: _____________ Zip: _________________

Hours and Fees: Days:___________________________ Time: ____________________________

Days Hourly: $___________ Nights Hourly: $____________ Overtime/Holidays: $____________

Payment: ☐ Weekly ☐ Bi-Monthly ☐ Monthly Payable by: ☐ Check ☐ Cash

Submit bills to: ☐ Member ☐ Representative

Income tax withheld: ☐ Yes ☐ No

Social Security paid by: ☐ Employer ☐ Employee ☐ Employer and employee

Social Security Number (if member agrees to pay taxes): ___________________________________

Vacation: ☐ Yes ☐ No If yes, weeks: ____________________

Care Needs: See attached

Housework and duties: See attached

When driving to appointments, whose car: ☐ Member ☐ Caregiver

Mileage Reimbursement: ☐ Yes ☐ No At __________/Mile

Other: ____

____

____

Visitors OK? ☐ Yes ☐ No OK to smoke while providing services? ☐ Yes ☐ No

Termination of Agreement:

Caregiver/Employee will give ___________ week(s) notice before quitting in order to give sufficient time to find another caregiver.

Member/Employer will give ___________ week(s) notice and $___________ when necessary to end this agreement.

____ ______________________

Employer Signature Date

____ ______________________

Independent Caregiver Signature Date