



CARENEST

CLIENT REGISTRATION FORM

APPLICANT'S INFORMATION (FAMILY MEMBER)

Title: Mr. () Mrs. () Miss () other: specify (.....)
Name of Applicant:
Tel No: Email (if any):
Residential Address:
Relation to Client:

CLIENT'S INFORMATION (PERSON TO RECEIVE CARE)

Title: Mr. () Mrs. () Miss () other: specify (.....)
Name of Client:
Date of Birth: Profession:
Marital status: (please tick) Single () Married () Widowed () Divorce ()
Tel No: Email (if any):
Residential address (GPS):
Health Condition of Client:

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HEMECARE SERVICES

Preferred Gender of Care providers: Male () Female () Both ()

Shift Required:

- a. 24-hours live-in (care providers will live with client) ()
b. 12- hours live-out (care provider do not live with client) ()



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WORKING DAYS

A. Monthly Shift

- Mondays to Sundays (30- 31 days) **GHS 2,000/month ()**

B. Weekday Shift only

- Mondays to Fridays (20- 22 days) **GHS 1,500/month ()**
- Mondays to Saturdays (26- 27 days) **GHS 1,800/month ()**

C. Weekend shift only

- Fridays to Sundays (3 days) **GHS 100/day ()**
- Saturdays & Sundays (2 days) **GHS 100/day ()**

MEALS

Nurse on duty is supposed to be provided with food:

Kindly select preferred option.

A. Meal for live-in 24hrs shift

1. Two Hot Meals to be provided by family, 2 times daily. ()
2. Family would provide food stuff to the nurse to prepare his/her own food ()
3. Family will provide weekly food allowance (cash, GHS 30.00 per day) for Nurse to buy his/her own food (GHS 210.00 for 7 days) ()

B. Meal for live-out 12hrs shift

1. Nurse must be provide with 1 hot meal (Lunch) per day ()
2. Family would provide food stuff to the nurse to prepare his/her own lunch ()
3. Family will provide weekly food allowance (cash, GHS 20.00 per day) for nurse to buy his/her own lunch ()

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CONCLUSION

- This agreement is subjected to annual review by both parties.
- The client may terminate this agreement at any time by giving a notice in writing or phone call to the Manager (0554826404) at least one (1) month in advance. Failure to do so will attract 50% of your monthly bill.
- The agency on the other hand will replace nurses at most three (3) times per the request of the client to change his / her nurse.
- Kindly note that you cannot engage the services of our nurses privately.



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- This memorandum of understanding constitutes the entire understanding of the parties, and any change shall be in writing and sign by both parties. Memorandum of understanding has been executed by each of the parties as of the date first written above.

MEMORANDUM OF UNDERSTANDING

This memorandum of understanding is made thisday of between Carenest Homecare Services and
Having undergone preliminary needs assessment, I
hereby accept the contract with Carenest Homecare Services on the terms and conditions.

SIGNATORIES

- Agreed and sign on behalf of **Client**

Name:

Sign:

Date:

- Agreed and sign on behalf of **Nurse**

Name:

Sign:

Date:

- Agreed and sign on behalf of **Carenest Homecare Services**

Name:

Sign:

Date: