Colorado CareAssist
COLORADOCAREASSIST.COM

Contact Name: _____ Telephone: _____ Date: 1/7/2026 Taken by: _____

Client Name: _____ Relation to Contact: _____ Referral: _____

Current Situation:	

Assessment Date:	**Time:**	**Address:**

Assessment

Diagnosis: _____ Care Goal: _____

Care Plan:	

Likes: _____

Dislikes: _____

Advanced Directives: DNR ___ MOST ___ POA ___ MPOA ___

About the home: Pets: No ___ Yes _____ Smokes: No ___ Yes ___

Caregiver Preference: Female ___ Male ___ Either ___ Add'l Preferences: _____

Proposed Schedule:	
Required Tasks:	

Plan For Payment

Private Pay: ___		
Long Term: ___	Provider:	Policy #:
	Daily Benefit Maximum:	Life Benefit Maximum:
Voucher: ___	Provider:	Limit:

Bill Rate: _____

Notes

_____

_____

_____

Colorado CareAssist Inc.	

CLIENT INFORMATION

Client Name: _____ Home Phone: _____

Client Address: _____

Client Email: _____ Cell Phone: _____

Birth Date: _____ Diagnosis: _____ Referral: _____

CONTACTS

Emergency Contact: _____ Cell Phone: _____

Care Contact: _____ Cell Phone: _____

Other Contact: _____ Cell Phone: _____

Payer Name: _____ Cell Phone: _____

Payer Address: _____

Payer Email: _____

PAYMENT

___ ***Online Payment*** **(Bank-to-Bank, Automated Clearing House)**

All invoices will be sent to the payer's email account (see above). Accompanying the invoice will be a link to Intuit's secure financial processing website. The payer can then enter the account information for the desired account for payment.

___ ***Electronic Transaction*** **(Credit Card, Paypal, Venmo, Zelle)**

I authorize Colorado CareAssist to initiate an electronic debit against the following account when a payment is due. This authority will remain in effect until I notify Colorado CareAssist in writing to cancel it. I agree to adding a 3% charge to cover the transaction processing fee.

Bank: _____ Routing #: _____ Account #: _____

Card #: _____ Expires: _____ CVC Code: _____ Billing Zip: _____

Signature: _____ Date: _____

If applicable, Client Representative's name/relationship: _____

All receipts will be sent to the payer (see above) via email: ____ or U.S. mail: ____

___ ***Check***

All invoices will be sent to the payer (see above) via email: ____ or U.S. mail: ____

___ ***Third Party Payer (e.g. LTC Provider, etc.)***

All Invoices will be sent to the payer (see above)

_____

_____

_____

Name of Agency: Colorado CareAssist

AGENCY DISCLOSURE NOTICE

Agency Type: ☐ Home Care Placement ☐ Home Health Care ☑ Personal Care or Non-Medical

Each home care agency or home care placement agency is required to provide the consumer information as to the responsibilities of the agency, the home care worker, and the consumer regarding the employment and duties of each.

☑Agency is the employer of record for all staff providing direct care services and is responsible for all items listed below.

☑Responsibilities are delineated below:

Consumer	Worker	Agency	
		✓	Employer of the home care worker.
		✓	Supervision of the home care worker.
		✓	Scheduling of the home care worker.
		✓	Assignment of duties to the home care worker.
		✓	Hiring, firing and discipline of the home care worker.
✓			Provision of supplies or materials for use in providing services to the consumer.
		✓	Training and ensuring qualifications that meet the needs of the consumer.
		✓	Liability for the home care worker while in the consumer's home.
Consumer	Worker	Agency	Payment of:
		✓	Wages to the home care worker.
		✓	Employment taxes for the Home Care Worker.
		✓	Social Security taxes for the Home Care Worker.
		✓	Unemployment insurance for the Home Care Worker.
		✓	General liability insurance for the Home Care Worker.
		✓	Worker's Compensation for the Home Care Worker.
		✓	Bond Insurance (if provided).

The above information and areas of responsibility have been explained and any questions have been answered in regard to responsibilities held by the consumer, the home care worker and the agency.

Consumer or Authorized Representative: _____ Date: 1/7/2026

Home Care Worker: _____ Discipline: _____ Date: _____
(if not employee or contractor to the agency where the agency holds full responsibility)

Agency Representative: _____ Title: Owner Date: 1/7/2026

Printed Name of Consumer: _____ Start of Care Date: _____

CDPHE 3/2009

Written Notice of Home Care Consumer Rights

As a consumer of home care and services you are entitled to receive notification of the following rights both orally and in writing. **You have the right to exercise the following rights without retribution or retaliation from agency staff:**

1. Receive written information concerning the agency's policies on advance directives, including a description of applicable state law;

2. Receive information about the care and services to be furnished, the disciplines that will furnish care, the frequency of proposed visits in advance and receive information about any changes in the care and services to be furnished;

3. Receive care and services from the agency without discrimination based upon personal, cultural or ethnic preference, disabilities or whether you have formulated an advance directive;

4. Authorize a representative to exercise your rights as a consumer of home care;

5. Be informed of the full name, licensure status, staff position and employer of all persons supplying, staffing or supervising the care and services you receive;

6. Be informed and participate in planning care and services and receive care and services from staff who are properly trained and competent to perform their duties;

7. Refuse treatment within the confines of the law and be informed of the consequences of such action;

8. Participate in experimental research only upon your voluntary written consent;

9. Have you and your property to be treated with respect and be free from neglect, financial exploitation, verbal, physical and psychological abuse including humiliation, intimidation or punishment;

10. Be free from involuntary confinement, and from physical or chemical restraints;

11. Be ensured of the confidentiality of all of your records, communications, and personal information and to be informed of the agency's policies and procedures regarding disclosure of clinical information and records;

12. Express complaints verbally or in writing about services or care that is or is not furnished, or about the lack of respect for your person or property by anyone who is furnishing services on behalf of the agency.

If you believe your rights have been violated you may contact the agency directly:

Colorado CareAssist 1911 11th Street, Floor 2, Boulder CO 80302

You may also file a complaint with the Health Facilities and Emergency Medical Services Division of the Colorado Department of Public Health and Environment via mail or telephone:

4300 Cherry Creek Drive South
Denver, CO 80246
303-692-2910 or 1-800-842-8826

I attest to verbal and written receipt of the aforementioned notice of rights:

_____	1/7/2026 _____
Client or Client's Agent Signature	Date
_____	1/7/2026 _____
Agency Representative Signature	Date

Colorado CareAssist Inc.	

SERVICE AGREEMENT

This Agreement on behalf of _____ **(CLIENT)** who resides at:

_____

is entered into between _____ (**CLIENT OR CLIENT'S AGENT**)

and **Colorado CareAssist Inc.** (**CCA**).

RECITAL

CLIENT or CLIENT'S AGENT desires to hire CCA to provide a live-in or hourly "Caregiver" under the terms and conditions herein stated, and CCA desires to provide those services to CLIENT.

1. **Duties of CCA:** CCA will provide a live-in or hourly Caregiver to render services in the CLIENT's home on a 24-hour a day or hourly basis. CCA is responsible for the agency responsibilities as outlined in the "Rights and Responsibilities" form included with this Agreement. Services are directed by the individual's Client Care Plan and may include duties such as: light housework, grocery shopping, meal preparation, personal care, and other tasks. CLIENT or CLIENT'S AGENT expressly acknowledge that the Caregiver is not medically trained nor is the Caregiver licensed to provide medical or nursing care, and that such services are therefore not included in this Agreement.
2. **Obligation of CLIENT:** CLIENT or CLIENT'S AGENT, or any financially responsible party under this Agreement shall pay for:
   a. The initial agreement is for _____ hours per visit, _____ visits per week and $ _____ per [ ] hour / [ ] day. Additionally: _____. This agreement can be changed, as needed.
   b. CLIENT or CLIENT's AGENT, or any financially responsible party agree to pay *ONE AND A HALF* times the agreed upon rate for the following holidays: New Year's Day, Easter Day, Memorial Day, Labor Day, Independence Day, Thanksgiving Day, and Christmas Day.
   c. The Service Period is [ ] semi-monthly or [ ] monthly. Payment for all services will be due upon receipt of an invoice from CCA at the end of each Service Period
   d. A deposit of $ _____ will be collected prior to the start of service. The deposit is retained by CCA and applied to the final service period. The deposit is waived for clients who authorize CCA to initiate Automated Clearing House (ACH) transactions for payments, including Service Period payments.
   e. Due to potential changes in CLIENT'S physical and/or mental health condition, and due to potential economic or regulatory changes, CCA reserves the right to reassess the fee. CCA will notify CLIENT of a fee change three (3) weeks prior to the start of any Service Period.
   f. CLIENT or CLIENT'S AGENT shall provide adequate, proper and reasonable accommodations for Caregiver's (a) working conditions, and (b) sleeping conditions, if applicable.
3. **Supplies and Equipment:** CLIENT or CLIENT'S AGENT is responsible for supplying all supplies (i.e. cleaning, personal care etc.) and equipment which may be necessary in the provision of services. Extra charges will apply if the Agency provides the supplies and/or equipment.
4. **Expense Reimbursement:** Any customer-approve, direct expenses incurred by the Caregiver on behalf of CLIENT shall be reimbursed by CLIENT or CLIENT'S AGENT, or any financially responsible party, directly to the Caregiver within seven (7) days such expenses are presented to CLIENT. Anticipated expenses may include, but are not limited to, groceries, parking, bus fare, etc. If the Caregiver's own vehicle is used for transportation of CLIENT, or for CLIENT's needs, CLIENT or CLIENT'S AGENT, or any financially responsible party will be billed for the transportation services on behalf of the Caregiver at a usage rate of .655 cents per mile.
5. **Severe/Bad Weather:** In severe weather, CCA may determine it is not safe for our Caregiver to travel and provide services to your home that day and may have to cancel that day's service. When this occurs, we will notify you and reschedule. Every attempt will be made to reach the client's home.
6. **Client's Rights and Responsibilities:** CLIENT or CLIENT'S AGENT responsibilities are outlined on the enclosed "Rights and Responsibilities" form. You are also responsible for securing personal property to decrease the possibility of theft.

7. **Late Fees:** All monies due but not received within 30-days of the invoice date will be subject to a monthly late fee of 5% of the overdue amount.

8. **Financially Responsible Party:** CLIENT, CLIENT'S AGENT, or other signor of this agreement whether acting in an official capacity or not shall become the Financially Responsible Party(ies). The Financially Responsible Party(ies) shall become guarantor(s) of the terms of this agreement and agree to be jointly and severally liable for all payments under the terms of this agreement including payment of the Service Period Payments hereunder.

9. **Employment Solicitation/Liquidated Damages:** CLIENT and CLIENT'S AGENT expressly acknowledge that CCA has invested time and money into the development of its Caregiver staff and hereby specifically and unequivocally agree not to solicit or accept the employment of any current or former Caregiver of CCA within 12 months following receipt of Caregiver services from CCA. Any such attempt constitutes a breach of this Agreement. Such breach is grounds for immediate termination of the Agreement and forfeiture of all monies paid to CCA. Because the damage suffered by CCA in the event of such breach would be difficult to ascertain, CLIENT agrees to pay a liquidated damages amount equaling three (3) Service Period Payments within ten (10) days of receiving written demand from CCA. CLIENT and/or CLIENT'S AGENT may be subject to any and all other legal remedies and actions available to CCA. This provision shall survive the termination of this Agreement.

10. **Term of the Agreement:** The term of this Agreement is indefinite and shall be renewed by timely receipt of the next Service Period payment. Except as otherwise provided herein, this Agreement may be terminated by either party with or without cause upon two (2) days prior written notice. In the event CLIENT is hospitalized, CCA will suspend Caregiver services until CLIENT returns from the hospital. Such a temporary interruption or suspension of service will not terminate this Agreement. The Agreement may be terminated by CCA without two (2) days' notice if in its sole and absolute discretion it determines that any of the following events has occurred:
    a. CLIENT becomes abusive in any way to or endangers the health or safety of the Caregiver.
    b. CLIENT requires sustaining care that does not permit the Caregiver to receive adequate sleep. "Adequate sleep" for the purpose of this Agreement means at least six (6) hours of sleep in any given 24-hour period, including an uninterrupted and continuous period of at least four (4) hours.
    c. CLIENT, or Financially Responsible Party fails to pay the required amount owed within 60 days of invoice date.
    d. CLIENT needs full-time care by a licensed healthcare professional or needs to be institutionalized.

11. **Entire Agreement:** This Agreement constitutes the entire agreement between CLIENT and CCA and supersedes any prior oral or written agreements and can only be amended in writing by mutual consent. There are no other representations, agreements, arrangements, or understandings, oral or written, between CLIENT and CCA relating to this Agreement or its subject matter.

12. **No Assignment:** Neither CCA nor CLIENT may assign this Agreement without express written consent by both parties.

13. **Severability:** In the event any provision of this Agreement is unenforceable, the remaining provisions shall not be affected and shall remain in full force and effect.

14. **Release of Healthcare Information**: CLIENT hereby authorizes the following individual(s) to exchange health care information with CCA employees for the purpose of creating and maintaining an optimal Care Plan that includes support for CLIENT healthcare needs: _____

15. **Other:** _____

Effective as of this _____ day of _____, _____ at _____, Colorado.

_____ 1/7/2026
Consumer or Authorized Representative Signature Date

_____ 1/7/2026
Financially Responsible Party Signature Date

_____ 1/7/2026
Agency Representative Signature Date

Colorado CareAssist Inc.	

Transportation Liability Waiver

[ ] I request and authorize Colorado CareAssist Inc.

- or -

[ ] I decline and do not authorize Colorado CareAssist Inc.

to transport _____
Name of Client

in the Client's vehicle or in another vehicle provided by or for the Client.

I understand that all Personal Care Workers, who are employed by Colorado CareAssist Inc., who are assigned transporting duties, are required to have valid drivers' licenses and carry relevant vehicle insurance including Personal Injury Protection.

I understand that Colorado CareAssist Inc. checks their employees' driving records to ensure they are free from infractions.

I understand that Colorado CareAssist Inc. reviews the currency of employees' driver licenses and motor vehicle insurance coverage but does not perform safety inspections or monitor maintenance on employee-provided or employee-owned vehicles.

I understand that Colorado CareAssist Inc. does not provide vehicle insurance for employee-owned vehicles.

I acknowledge that driving is risky and can result in serious injury or death.

I assume the risk of riding in motor vehicles of Colorado CareAssist Inc. or its employees and I forever discharge and release the Agency and its employees from any and all claims, including their own negligence, which may arise out of the operation of motor vehicles in which I am riding.

I acknowledge that I am responsible for my own vehicle insurance during all times that a Colorado CareAssist Inc. employee uses my vehicle or any vehicle that I supply.

I have read and voluntarily agree to sign this Transportation Liability Waiver.

_____ 1/7/2026

Client or Client's Agent Signature — Date

_____ 1/7/2026

Agency Representative Signature — Date