N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING SERVICES

AGREEMENT FOR IN-HOME AIDE SERVICES: LEVEL I- HOME MANAGEMENT

This Agreement establishes a working understanding between the In-Home Aide Services recipient/ family, In-Home Aide, and the N.C. Division of Services for the Blind regarding the service(s) to be provided. The Aide is employed by the DSB consumer and the Division acts as the agent for the consumer in filing Social Security taxes (FICA). A form 2678 Employer Appointment of Agent must be completed by each recipient of In-Home Level I and filed with the Chief of Independent Living Services. Changes in this Agreement may be requested by either of the signers. For significant changes, the Agreement must be rewritten. For minor changes, notations will be made on this document and signers will initial and date them on page 4. If no changes need to be made when annual redetermination is made, write date of redetermination and "no change" on previous year's agreement.

Consumer's Name: _____

Phone Number: _____

In-Home Aide Name: _____

Phone Number: _____

Address: _____

_____

Social Security Number: _____

Below are Level I- Home Management Tasks. Indicate by an "X" and tell how often performed.

☐ Clean/ care for clothing: ironing, simple mending, laundering

_____

☐ Do basic housekeeping task: sweeping, dusting, vacuuming, dishes, mopping

_____

☐ Make minor repairs to house and furnishings

_____

☐ Make unoccupied bed

_____

☐ Recognize/ report changes in health/ environment

_____

☐ Identify medications for consumer

_____

☐ Prepare simple meals

_____

☐ Shop for food from verbal or written instruction

_____

☐ Observe/ report symptoms of abuse, neglect, illness, etc., to proper professional

_____

☐ Other _____

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Specific Hours Worked/ Day: _____

Total Hours/ Day: _____

Specific Days Worked/ Week: _____

Number of Days: _____

Aide's Beginning Date for Service: _____

Rate of Pay: $ _____ Hr. Maximum Hours/ Mo _____

The consumer and In-Home Aide agree to the services listed above and to the hourly rate of pay. The In-Home Aide understands that he/ she will take _____ hours of training or states he/ she has had _____ hours of training.

The Division of Services for the Blind is not responsible for hours worked by an In-Home Aide in excess of those specified in this agreement.

Aide statement: I, _____, understand that I am not employed by the Division of Services for the Blind but I am employed as an In-Home Aide by _____.

Client statement: The Division acts as my agent for matters dealing with payment for the services I receive.

We, the undersigned, agree with the stated plan:

Consumer: (or Family Member/ Responsible Person) _____

Date: _____

In-Home Aide: _____

Date: _____

Changes in Agreement for In-Home Aide Services: Level I-Home Management

Initials:

Consumer _____ Aide _____ Date _____

Consumer _____ Aide _____ Date _____

Consumer _____ Aide _____ Date _____

Distribution:

Original- Consumer's Case Record

Copy- Consumer

Copy- In-Home Services Aide