



## Membership Application

First name: \_\_\_\_\_ M \_\_\_\_ Last: \_\_\_\_\_ M \_\_\_\_ F \_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Current Age: \_\_\_\_ Today's date: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

(Please circle Yes or No answer)

A. I am currently under care or have been told by a medical professional that I will need care within the next 90 days. **YES / NO**

B. I have been diagnosed with Alzheimer's, Dementia, Cancer, late-stage Parkinson's, or similar illness. **YES / NO**

**If questions A and B are answered NO, the plan can be field issued as an Elite plan. A corporate review will be followed for a final membership approval and issuance of documents. If either question is answered yes, the home office of AHCS will offer a customized plan to the Representative to be presented to the applicant.**

### Home Health Care Membership Plans

Membership Plan Selected: ELITE: \_\_\_\_\_ HOURS: \_\_\_\_\_ or Customized Plan: \_\_\_\_\_

Check payment method: 1-pay \_\_\_\_ 10-pay \_\_\_\_ A \_\_\_\_ S/A \_\_\_\_ Q \_\_\_\_ NOTE: 10 pay requires annual payments.

I elect  / I decline  - Amaze Health MD Tele-Med services for \$25 a month or annual payment of \$295

Please make checks payable to: **American Home Care Services**, for credit card transaction see authorization form.

Renewal Membership plans are paid by ACH auto bank draft or credit card ACH depending on the Member's preference. Please check desired renewal methods.

Credit Card \_\_\_\_ or Auto bank draft \_\_\_\_ (Member's Initials) \_\_\_\_\_

Mode: Annual \_\_\_\_ Semi-annual \_\_\_\_ Quarterly \_\_\_\_ Monthly \_\_\_\_

Membership Plan Cost: \$ \_\_\_\_\_

Amaze Health Tele-Med: \$ \_\_\_\_\_

Total amount due today: \$ \_\_\_\_\_

Members Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Representative's / Witness signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Representatives I.D. #: \_\_\_\_\_

360 Central Avenue Suite 800 Saint Petersburg, FL. 33701

Phone: 727-823.2300 Toll Free: 877.495.4847 Email: [customercare@ahcareservices.com](mailto:customercare@ahcareservices.com) Website: [www.ahcareservices.com](http://www.ahcareservices.com)

## Membership Agreement

The following agreement represents Aurora Home Care Services, LLC a Florida Limited Liability Company, dba American Home Care Services (AHCS) Enrollment, Terms, Conditions and Membership Agreement. (Collectively, the "Member Agreement"). The member has provided payment for membership plan \_\_\_\_\_ which provides Membership hours of \_\_\_\_\_ in the sum of \$ \_\_\_\_\_ which covers a period of \_\_\_\_\_ months. In consideration of the payment for the Membership as described, American Home Care Services, (heretofore known as AHCS) agrees to provide payment for the home care services provided as indicated within the plan terms and conditions of the member's selected plan. Further explained under Terms and Services below according to and subject to the limitations, terms, and conditions of this contract (hereinafter Agreement). The Member will be referred to in this Agreement as the Member. American Home Care Services will hereafter be referred to as "AHCS" in this Agreement.

### TERMS:

The Membership Agreement is intended to provide payment for the selected plan / hours elected by the member. To qualify for a traditional member plan, known as the Elite Membership Plan, a member must be able to live independently at the time of enrollment and cannot currently need or receive any assistance with activities of daily living, such as but not limited to; bathing, dressing, cooking, medication assistance, assistance with walking or getting in and out of bed at the time of application enrollment. If an applicant does not meet the traditional Elite Membership requirements as outlined in this agreement, he or she is still entitled to apply for a membership. A member plan that is outside of the traditional Elite Plan is referred to the Customized plan. Addendum "A" allows the applicant and AHCS to design a customized plan for a member with health challenges. This plan will be subject to limitations and price adjustments. Custom plans represent a high-risk category and have limited hours of care available. The maximum hours allotted for a customized plan will vary depending on the applicant's health condition. The customized plans are created specifically for the individual need of the member. Customized plans do not offer a 10% discount, or a paid-up program as outlined in the traditional plans, however they do offer the same Loyalty Cash Back Reward Program, and a prorated refund at death of any unused hours as allowed in the Elite Membership plans. The outline of benefits for the customized plan is attached to this agreement as addendum "A". Please see details on addendum page. Both the Elite and Custom plans can access benefits after the 90-day waiting period has been satisfied.

**SERVICES:** American Home Care Service's (AHCS) Elite, and Customized membership plans arrange for non-medical Home Care services to be provided in the comfort of the member's home. Services will be arranged for Members up to the time that services are needed as outlined within the membership agreement. Custodial Services will be provided by a home care aid (care giver) or person of similar qualification. In-home care services do not include Medical Doctors (MD), Registered Nurses (RN), Licensed Practical Nurses (LPN), Licensed Vocation Nurses (LVN), Physical Therapist, or Licensed Physician Assistants (PA), however, through an affiliate program with Amaze Health, these medical professionals are available to our members (when selected) to answer medical questions and assess the members needs by phone, or zoom calls, known as Tele-med services. A member does not have to require home health care services to access the medical team at Amaze Health. Furthermore, the member has access 24 hrs. / 7-days a week for any question regarding medical concerns. If a member elects to waive the option to purchase the Amaze Tele-med service at time of the initial application, a membership will be required at time of claim to purchase a minimum of one month of a membership which is currently twenty-five dollars. To qualify for home health care benefits, the initial 90-day waiting period from date of issue must be satisfied. Once satisfied, the member must notify a customer care specialist at AHCS. The phone number is located on the front of the Membership Application , the Membership Agreement paperwork and the Member's I.D. card. Once the call has been initiated, the customer care specialist will arrange a phone or zoom call with a member at Amaze Health Tele-Med services. Amaze's medical team will assess the Member's health condition, as well as suggest a timeline for care to American Home Care Services (AHCS) on the Members behalf. If Amaze's evaluation concludes that the Member requires assistance with a minimum of two Activities of Daily Living (ADL'S), and the need for home health care is present, American Home Care Services will arrange services with a Licensed Home Health Care Agency to take care of the Member's home health care needs as outlined within the Member's membership agreement. If the member would prefer a family member or a friend to provide care, AHCS will coordinate with the individual the member selects as their custodial home care service provider. To arrange the appropriate care, services can take up to 72 hours to coordinate with the participating home care agencies. Normal operating hours of most Home Health Care Agencies are between Monday – Friday 9 a.m. to 5 p.m. however it can vary depending on the Home Health Care Agency selected. It is important to note that Amaze Health is not owned, operated, or partnered with or by AHCS. Amaze Health is its own separate entity. Payments from AHCS for a Member's home health care services are made directly to the Agency and not to the Member when utilizing a licensed Home Health Care Agency. When the Friends and Family Benefit feature is utilized, the payment by AHCS is made directly to the Member. Custodial Services provided under this agreement shall be suspended during such time that Member is hospitalized or becomes a resident of any skilled nursing facility or rehab center. AHCS may change home health care providers as they see appropriate. Additionally, the member has the right to select a different home care professional or a different agency if they are not satisfied with the care being provided. To receive care from the Family and Friend Care Option or a licensed Home Health Care Agency, the membership must be in effect for a period of ninety days (90) "Waiting Period" prior to receiving benefits. Each plan selected creates a bundle of hours divided into ten (10) separate bundles. Once the service hours in the initial bundle have been exhausted, following a 90-day Re-up Period (of non-use), the 2nd bundle of the selected plan hours can be accessed. A total of nine (9) Re-up periods occurs separating each bundle of hours that add up to the total Membership Hours of a member contract. All plans cover a period of twelve (12) months acting as its own term. Unused hours from a preceding term will rollover and be utilized before service hours in a new bundle can be accessed following a 90-day Re-up period. The home care hours of any plan can re-up for up to the "Maximum Membership Hours" which is a total of 10 times the initial bundle of hours of your chosen plan. Example: A 5000-hour membership plan would consist of ten 500-hour bundles. Multiple bundles of hours can be utilized within a twelve (12) month term within the parameters of the Membership agreement.

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AHCS's obligation of payment shall not be greater than the total number of hours listed within the Members plan selected on the application or on the addendum upgrade form. Plan payments may not exceed the daily maximum amount allowed for home health care services which is set at \$150.00 a day for the Elite and Custom plans. Twenty-four-hour care will be considered anything over an 8-hour period in a one day per period. This will require 24 hours to be used from the total hours in the selected plan. If 24-hour care is needed, care must be provided by a Home Health Care Agency or a person with similar skills / training. The family and friend benefits are not available for 24-hour care. Under the friend and family benefit plan option, the member will be required to sign a release of liability form for any injuries or damages that could occur by the members friend or family. In addition to the liability waiver, the selected friend or family must be approved by AHCS and obtain the caregiver training program certificate. The rate for Family and Friends option is \$15.00 an hour or a maximum daily benefit of \$75.00 for both the Elite and Custom plans. All payments under the friends and family option are made directly to the Member. Any Individual providing care must obtain payment directly from the member. The maximum benefit period for the Friends and Family Life Care Option is 90 days. A day is considered a calendar day, regardless of the number of hours that care is provided. Once exhausted, the Member will have access to traditional Home Health Care Services as outlined in their plan, however AHCS reserves the right to extend the family and friend care life option if it is in the best interest of all parties. The Friends and Family benefit offers a re-up benefit whereas the coverage restores itself for an additional 90-days of service after a period of 90-days of nonuse, as outlined in this agreement. To access benefits after the 90-day waiting period, the member must requalify under the same rules that apply initially regarding the need for assistance with two ADL'S or more. Unused hours shall carry over for use during any subsequent contract year. Custodial Services shall be provided only in hourly periods. If twenty-four hours of Custodial Services is needed, the Member must provide the home care aid suitable private sleeping quarters. AHCS will only pay for Custodial Services that are provided at the principal residence address of the Member disclosed in the application or a new established residence. If an address is different from the member's residency, AHCS would have to approve the location of care as acceptable under the terms of this agreement. If not approved by AHCS, the Member is free to arrange for custodial care other than through AHCS, however AHCS shall have no obligation to pay for services as outlined in the member's membership agreement.

### **DURATION AND PAYMENT**

Payment for home health care services by AHCS shall be provided only while the member agreement is in-force following the effective date set forth below. The initial payment and renewals may be paid by check or with credit cards. The initial membership agreement is for twelve (12) months following the effective date unless AHCS agreed otherwise in writing. This Agreement may be renewed annually, semi-annually, quarterly, or monthly. Any renewal of this agreement shall be for the time selected on the application unless the parties agree otherwise. Payment for the services to be provided under this Agreement may be made as set forth in the application. Renewals may be paid monthly, quarterly, semi-annual, or annual. Payments are due on or before the due date. Any payments received after the due date will be considered late and will trigger a cancellation notice. Members have up to 10 days past their due date to remedy their late payment. Payments must be in full. If the payment is not received in full within the 10-day grace period, AHCS will cancel the members agreement in its entirety and all benefits will cease immediately. The Elite plans are deductible free; however, the Customized plans can be subject to deductibles and or exclusions under certain circumstances which would be explained in writing prior to issuing the plan.

### **LIMITATIONS CONCERNING CUSTODIAL SERVICE**

Custodial home health care services may be denied to the Member if the Member, or the Member's spouse, or any other person residing at Member's residence, shall have been charged or convicted of a crime involving violence or moral turpitude, domestic battery or violence is committed or threatened against a home care aid provided pursuant to this Agreement, this Agreement shall terminate immediately. No refund will be provided to the member under these circumstances.

### **AGREEMENT IS NOT A CONTRACT OF INSURANCE**

Member and AHCS agree that this Agreement does not constitute a contract of insurance. Member agrees to notify AHCS in writing within ten (10) days of receiving this Agreement, if any person who procured the application for this Agreement made a misstatement to Member that induced Member to enter into this Agreement, Member's sole remedy shall be against the person making the false or misleading statement. Member waives the right to seek any other damages, remedy, or relief from AHCS. I am aware that this Membership agreement is a service contract that pays for a set number of hours of custodial home care services. Furthermore, I am aware that this Member Plan is NOT AN INSURANCE POLICY.

### **RESCISSION RIGHTS**

Member's application to AHCS shall be Member's offer to enter into a Member Agreement with AHCS. If AHCS accepts Member's offer to enter into an Agreement, the Agreement shall go into effect on the effective date so stated on the application. Only an authorized representative of the home office may accept or deny a member's application for membership. A Membership may be denied by home office for any reason home office deems necessary. In the event home office denies the applicant, a refund check will be issued to the applicant in full within 48 hours and sent to the address on the application. The application is a part of the Membership Agreement. If Member's application is accepted by AHCS, The Member may rescind this agreement within three (3) days of the effective date. To rescind this Agreement, Member must deliver the signed cancellation notice to the business address or email address of AHCS as listed on the enrollment application, within the said three (3) day period of the signed member enrollment effective date. The date posted on the email or envelope by the U.S. Mail Service shall be the date referenced to determine if the cancellation request was received within the three-day period. If a cancellation was requested and received within the three-day period, a full refund shall be made to Member within fourteen (14) business days.

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After the three-day rescission period has passed, as described in the payment and duration section above, the Member may cancel their membership at any time, however AHCS is under no obligation to refund any portion of the members plan premium after the rescission period has expired. In the event of death, the member's estate, or designated beneficiary(ies) will be entitled to receive a proration of a refund equal to the unused coverage for the year the member passed less any claims that were paid on the members behalf during the time the membership was active. A death certificate must be received within 90 days from the date of passing.

## LIMITATIONS AND DEFAULT

AHCS does not direct, supervise, or employ the home health care aid working for the home health care agencies or person of similar qualification, the parties hereto agree that AHCS is not responsible for the acts or omissions, including negligence or intentional tort, of the home care aid, or person of similar qualification, or the Agency for whom the home care aid or person of similar qualification may work or be directed. Furthermore, in the event that AHCS is unable, for whatever reason, to arrange for a home care aid or person of similar qualification for the time period that Member requires to meet his or her custodial care needs, AHCS's liability to Member hereunder is limited to the cost to Member for obtaining the Custodial Services of a home care aid or person of similar qualifications. Member waives the right to seek or recover any other damages or remedy.

- **COST OF LIVING ADJUSTMENT BENEFIT:** Our plans provide built-in inflation protection. As prices in the home health care increase, AHCS will provide the payments to the home health care agencies regardless of the increase. In addition, as the payments to home health care agencies increase, the premium to our members does not increase!
- **HEALTH AND LOYALTY CASH PROGRAM:** This benefit provides cash back to the member by rewarding the member for staying healthy. To qualify for this benefit, the member must be claim free for the first 5 years of their membership. AHCS will refund the member 50% of the 6<sup>th</sup> year annual payment which equals 10% of all premiums paid for the first five years of service. This refund will be paid to the member if the membership is still active / in-force and the renewal for the 6<sup>th</sup> year is not lapsed. Benefit does not apply to the custom or 10-pay plans.
- **EMERGENCY BENEFIT:** Within the initial 90 day waiting period of a new membership being issued, a member may access limited benefits of their plan if an unexpected hospital stays, or emergency occurs. The plan must be in effect for 3 days before benefits can be accessed. The maximum benefit for this feature is 20% of the maximum daily allowance under this contract. This benefit is limited to a 30-day period. This benefit requires verification from a medical professional involved with treatment.
- **OPTION TO PURCHASE MORE HOURS:** This option is only available one time during the lifetime of the Membership Plan Agreement. Additional hours may be purchased within 14 days of the member's plan renewal period. The 14-day open enrollment period can be 14 days before or after the renewal period. The member may increase hours in any year they select without the proof of medical records, however the member CANNOT be under medical or custodial care or be advised by a physician or medical professional that they need care within the next 90 days at time of hour upgrade. If the member is qualified to upgrade member hours, all hours are automatically accepted up to a maximum combined benefit of 10,000 hours.
- **FRIEND AND FAMILY SERVICE PROVIDER:** If a member feels more comfortable with a friend or family member providing care in their home, AHCS offers a Friend and Family benefit to all our members. For details see member agreement outline.

## ENTIRE AGREEMENT

This written Agreement constitutes the entire Agreement between AHCS and the Member, and no other contract exists between the parties hereto. No statement or representation made by the person(s) who enrolled Member into this Membership is binding on AHCS unless contained in an addendum hereto signed by AHCS's executive officer. Member furthermore agrees with AHCS that no statement or representation concerning this Agreement acted as an inducement to Member to enter into this Agreement unless such statement or representation is reduced to writing attached hereto. Only an Officer of AHCS has the authority to modify the terms of this Agreement, and Member agrees that no other person may do so. Member may not assign this Agreement, nor any rights or benefits arising from or under this Agreement, without the express written consent of AHCS. The jurisdiction of this Agreement is in the state of Florida and shall be governed accordingly. If any provision of the Agreement is held to be invalid, illegal, or unenforceable under any applicable statute or rule of law, then the balance of the Agreement shall continue in full force and effect. Any action or suit to enforce this Agreement, or obtain damages for its breach, may only be brought in Pinellas County, Florida and this agreement is subject to the law of the State of Florida. The representations of Member made in the application were relied upon by AHCS in determining whether to enter into this Agreement with Member. If, following the issuing of this Agreement, AHCS should learn that Member made a misrepresentation, whether intentionally or negligently, in his or her application, AHCS reserves the right to either cancel or rescind this Agreement. Membership Terms and Conditions may be amended from time to time by AHCS. Benefits may be added or modified if AHCS finds it necessary. Any change would require a written 90-day notice by AHCS to all members.

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**Member:** I have read and understand the Terms and Conditions of the Membership Agreement.  
The representative personally explained the benefits, options, restrictions, and limitations of the selected member plan.

\_\_\_\_\_  
Member printed name

\_\_\_\_\_  
Member Signature

Date Signed: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Representative printed name

\_\_\_\_\_  
Representative Signature

Date Witnessed \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**To initiate home care services please call AHCS customer care at:**

**727.823.2300, or 877-495-4748**

**A customer care representative will be happy to assist you with your plan of care.**

**Thank you for being a valued member.**

**The Membership Agreement containing a full set of documents, receipts, brochure, and I.D. Cards will be mailed to you directly from AHCS home office once the Membership has been issued. Please provide your email address to receive an electronic version of your documents. Electronic documents are in addition to your hard copy version, unless you elect that you only want an electronic version.**

**Addendum "A"**

This addendum pertains to the **Customized** feature of the membership plan as described in this member agreement.

**Requested Home Health Care Benefits:**

**Hours of care per day:** \_\_\_\_\_

**Period of time care provided:** Weeks \_\_\_\_\_ Months \_\_\_\_\_ Years \_\_\_\_\_

**Total amount of hours of care provided over life of membership plan:** \_\_\_\_\_

I would like to apply for a customized home health care member plan: I am aware that I am under no obligation to accept the plan offered to me by home office. Further I understand that I am not responsible to provide payment now. Payment would only be required if I accept the custom plan that is being offered to me by AHCS, and only after I have had time to review the entire plan with a representative of AHCS.

X \_\_\_\_\_  
Member printed name

X \_\_\_\_\_  
Member signature

X \_\_\_\_\_  
Representative

X \_\_\_\_\_  
Representative Printed Name

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Today's date



## Client Survey

**I have received the following documents, explanations and have acted on my own free will.**

- A complete explanation of my Membership Agreement.
- A copy of the Membership application and a signed receipt (Copy of the Application will be mailed to me).
- Representative explained to me that American Home Care Service is a membership plan and **not** insurance.
- An explanation that I should not cancel any insurance program or other insurance or noninsurance contract/agreement due to this membership.
- The representative explained to me that I was under no obligation, and he/she presented no pressure.
- A clear understanding of AHCS terms and conditions were explained to me.
- The representative presented his / herself in a courteous, knowledgeable, and professional manner, without any forceful tactics.
- I have read and understand the client survey and have approved it freely and with complete understanding.
- **I am aware that I will be provided a copy of my application, Terms and Conditions, Member Agreement, and I.D Card from the home office of American Home Care Services once my plan is issued. Email copies are available too.**

Client Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Representative Signature: \_\_\_\_\_ Printed Name: \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_



## Representative Survey

- I explained the AHCS Membership Agreement in its entirety. The agreement and all terms and conditions were accepted by the client who I believe to be of sound mind and capable of executing all documents.
- I did not observe any mental or physical conditions which would impair the client's ability to engage in the execution of the AHCS Application and Membership Agreement.
- The client is not currently hospitalized, institutionalized, receiving home or Nursing Home Care or been advised to engage in such care or received such care in the previous six (6) months from the date of the execution and of the Membership Application.
- I provided a signed receipt.
- I provided a Membership brochure.
- I provided a signed Membership Application.
- I provided a signed copy of the Membership Agreement
- I provided my cell number as well as the home office phone number for AHCS to the Member.

Representative's Signature \_\_\_\_\_

Printed Name \_\_\_\_\_

Rep ID # \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_





# Payment Authorization Form

**Here's How Recurring Payments Work** - You authorize regularly scheduled charges to your checking/savings account or credit card. You will be charged the amount indicated below each billing period. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

**Please complete the information below:**

I, \_\_\_\_\_, authorize **Aurora Home Care Services, LLC Db a American**  
(full name)

**Home Care Services** to charge my credit card or bank account as indicated below for \$ \_\_\_\_\_  
(amount)

every \_\_\_\_\_ for payment of my **American Home Care Membership Plan.**  
(Frequency - Monthly, Quarter, Semi-Annual, Annual)

**CREDIT CARD OR BANK ACCOUNT:**

Billing Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Email \_\_\_\_\_

**COMPLETE SECTION THAT APPLIES TO PAYMENT CHOICE:**

**Account Type:** \_\_\_\_\_ **Checking** or \_\_\_\_\_ **Savings**

**Financial Institution:** \_\_\_\_\_

**Name on Account:** \_\_\_\_\_

**Account #** \_\_\_\_\_ **Routing #** \_\_\_\_\_

**Card Type:** \_\_\_\_\_ **VISA** \_\_\_\_\_ **MasterCard** \_\_\_\_\_ **American Express** \_\_\_\_\_ **Discover**

**Name as appears on card:** \_\_\_\_\_

**Card #** \_\_\_\_\_ **Exp Date** \_\_\_\_\_ **CVV** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify **AMERICAN HOME CARE SERVICES** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that **American Home Care Services** may at its discretion attempt to process the charge again within 30 days and agree to an additional charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.