# Employer Pay Authorization

**Purpose:**
This form is used for Participant\Employer to authorize payment to their Caregiver\Employee which attest that a review of hours recorded through the attendance system is accurate and in accordance with the Individual Person of Service (IPOS).

| | | | |
|---|---|---|---|
| **Participant\Employer:** | | **Caregiver\Employee:** | |
| **PAS id:** | | **Payroll id:** | |
| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** _____ to _____ **Due Date:** _____ **Pay Date:** _____

I the Employer have reviewed the following before signing the Employer Pay Authorization Form:
**The following is necessary to process a Medicaid Claim.**
1. Verify the Employee days and hours worked
2. Verify the Employee has worked the schedule hours authorized
3. Verify the Employee has not exceed the Medicaid service authorization
4. Verify the Employee selected the tasks performed
5. Verify the Employee documented progress\visit note

I certify that the information recorded in the Attendance System is accurate and complete. Also with clocking in\out in the Attendance System I documented the daily tasks performed and daily progress\visit notes. My signature confirms all hours worked for the service period above was provided as face-to-face hours in accordance with my Employers Individual Plan of Service and Service Authorization. I understand that payment will be made based upon the Medicaid Service Authorization, recorded hours from the Attendance System, training requirements and payment is approved by the Funding Agency.

_____ _____
**Employee** **Date**

As the Employer or Representative I have reviewed and certify that my Employee's hours recorded in the Attendance System were performed as face to face services as outlined in the Individual Person Center Plan (IPOS). I authorize Personal Accounting Services, Inc. to pay my employee for the Medicaid services provided. I understand that if my employee has not completed or maintained the required trainings, Medicaid funding cannot be used, and it will be my responsibility to make payment to my Employee.

_____ _____
**Participant\Employer\Legal or Designated Representative** **Date**

**Submit form:** **Fax: (734) 720-1002**

Personal Accounting Services, Inc. - Employer Agent
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