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\Emplo	oyer:			Caregiver\E	Employee:		
PAS id:				Payroll id:			
Agency id:				Telephone:	Telephone:		
Telephone:							
Service address:							_
City, State, Zip:							_
<u>Service Period:</u> From:	07/01/2020	to	07/15/2020	Due Date:	07/16/2020	Pay Date:	07/31/2020
 Verify the Empl. 	ecessary to process oyee days and hours oyee has worked the oyee has not exceed oyee selected the ta oyee documented pr	worked schedule the Med sks perfor	e hours authorized icaid service authc rmed				
System I documente above was provided understand that pay	ormation recorded in t ed the daily tasks perfo l as face-to-face hours yment will be made ba ts and payment is app	ormed and in accorda sed upon t	daily progress\visit ance with my Employ the Medicaid Service	notes. My signat yers Individual Pla	ture confirms all ho an of Service and Se	ours worked for ervice Authoriza	the service period ation. I
	Er	nployee			_	Date	_
performed as face to pay my employee for	Representative I have o face services as outli or the Medicaid service funding cannot be use	ned in the es provided	Individual Person C d. I understand that	enter Plan (IPOS) if my employee l	. I authorize Person has not completed	nal Accounting or maintained t	Services, Inc. to
Part	icipant\Employer\Leg	al or Desi	gnated Representat	ive	_	Date	_
Submit form:	Fax: (734) 206- Personal Accou 20500 Eureka F	nting Ser	vices, Inc Employ 12	ver Agent			
	Taylor, MI 481 Telephone: (73		100				

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\Emplo	oyer:			Caregiver\E	mployee:		
PAS id:				Payroll id:			
Agency id:				Telephone:	Telephone:		
Telephone:							
Service address:							
City, State, Zip:							_
<u>Service Period:</u> From:	07/16/20 20	to	07/31/2020	Due Date:	08/01/2020	Pay Date:	08/14/2020
 Verify the Empl I certify that the info System I documente above was provided understand that pay	ecessary to process a oyee days and hours oyee has worked the oyee has not exceed oyee selected the tas oyee documented pr ormation recorded in the ed the daily tasks perfor d as face-to-face hours yment will be made bas its and payment is appro-	worked schedule the Medi sks perfor ogress\vi me Attenda rmed and in accorda sed upon t	e hours authorized icaid service autho med sit note ance System is accur daily progress\visit ince with my Employ the Medicaid Service	rization rate and complet notes. My signat yers Individual Pla	ure confirms all ho an of Service and Se	ours worked for ervice Authoriza	the service period ation. I
	En	nployee			_	Date	-
performed as face t pay my employee fo	Representative I have n o face services as outlin or the Medicaid service funding cannot be used	ned in the s provided	Individual Person Co d. I understand that	enter Plan (IPOS) if my employee l	. I authorize Person has not completed	nal Accounting or maintained t	Services, Inc. to
Part	icipant\Employer\Leg	al or Desig	nated Representati	ive	_	Date	
Submit form:	Fax: (734) 206-	1436					
	Personal Accour 20500 Eureka R Taylor, MI 4818	d Suite 1	vices, Inc Employ 12	ver Agent			

Telephone: (734) 729-3100

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\Empl	oyer:			Caregiver\E	mployee:		
PAS id:				Payroll id:			
Agency id:				Telephone:	Telephone:		
Telephone:							
Service address:							
City, State, Zip:							_
							-
<u>Service Period:</u> From:	08/01/2020	to	08/15/2020	Due Date:	08/16/2020	Pay Date:	09/01/2020
The following is n 1. Verify the Empl 2. Verify the Empl 3. Verify the Empl 4. Verify the Empl	ve reviewed the follo ecessary to process oyee days and hours oyee has worked the oyee has not exceed oyee selected the tag oyee documented pr	a Medica worked schedule the Medi sks perfor	id Claim. hours authorized icaid service autho med		norization Form:		
System I document above was provided understand that par	ormation recorded in t ed the daily tasks perfo d as face-to-face hours yment will be made bas nts and payment is app	ormed and in accorda sed upon t	daily progress\visit ince with my Employ he Medicaid Service	notes. My signat yers Individual Pla	ure confirms all ho an of Service and Se	ours worked for ervice Authoriza	the service period ation. I
	Er	nployee				Date	
performed as face t pay my employee fo	Representative I have i to face services as outli or the Medicaid service funding cannot be used	ned in the s provided	Individual Person Co d. I understand that	enter Plan (IPOS) if my employee l	. I authorize Person has not completed	nal Accounting or maintained t	Services, Inc. to
Part	ticipant\Employer\Leg	al or Desig	nated Representati	ive		Date	
Submit form:	Fax: (734) 206-	1436					
	Personal Accou 20500 Eureka R Tavlor MI 4818	d Suite 1	vices, Inc Employ 12	ver Agent			

aylor, i Telephone: (734) 729-3100

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Participant\Emplo	oyer:			Caregiver\E	Employee:		
PAS id:				Payroll id:			
Agency id:				Telephone:	_Telephone:		
Telephone:							
Service address:							
City, State, Zip:							
							_
<u>Service Period:</u> From:	08/16/2020	to	08/31/2020	Due Date:	09/01/2020	Pay Date:	09/15/2020
The following is n 1. Verify the Empl 2. Verify the Empl 3. Verify the Empl 4. Verify the Empl 5. Verify the Empl 1 certify that the info System I documented above was provided understand that pay	ve reviewed the follo ecessary to process oyee days and hours oyee has worked the oyee has not exceed oyee selected the tas oyee documented pr ormation recorded in t ed the daily tasks perfor l as face-to-face hours yment will be made bas its and payment is app	a Medica worked schedule the Medi sks perfor rogress\vi he Attenda ormed and in accorda sed upon t	id Claim. e hours authorized icaid service authorized imed sit note ance System is accur daily progress\visit ince with my Employ the Medicaid Service	rization ate and complete notes. My signat yers Individual Pla	e. Also with clockin ture confirms all ho an of Service and So	ours worked for ervice Authoriza	the service period ation. I
	Er	nployee			_	Date	_
performed as face t pay my employee fo	Representative I have o face services as outli or the Medicaid service funding cannot be use	ned in the es provided	Individual Person Code I understand that	enter Plan (IPOS) if my employee l	. I authorize Perso has not completed	nal Accounting or maintained t	Services, Inc. to
Part	icipant\Employer\Leg	al or Desig	gnated Representat	ve		Date	
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	Personal Accou 20500 Eureka R Taylor, MI 4818	d Suite 1	vices, Inc Employ 12	ver Agent			

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PAS id:				Payroll id:			
Agency id:				Telephone:	Telephone:		
Telephone:							
Service address:							_
City, State, Zip:							_
<u>Service Period:</u> From:	09/01/202 0	to	09/15/2020	Due Date:	09/16/2020	Pay Date:	10/01/2020
 Verify the Emploid Verify the Emploid Verify the Emploid Verify the Emploid 	ecessary to process byee days and hours byee has worked the byee has not exceed byee selected the ta byee documented pr	worked schedule the Med sks perfo	e hours authorized icaid service authc rmed				
System I documente above was provided understand that pay	prmation recorded in t ed the daily tasks perfor as face-to-face hours rment will be made ba ts and payment is app	ormed and in accorda sed upon t	daily progress\visit ance with my Employ the Medicaid Service	notes. My signat yers Individual Pla	ture confirms all ho an of Service and S	ours worked for ervice Authoriza	the service period ation. I
	Er	nployee			-	Date	-
performed as face to pay my employee fo	Representative I have o face services as outli or the Medicaid service funding cannot be use	ned in the es provide	Individual Person C d. I understand that	enter Plan (IPOS) if my employee l	. I authorize Perso has not completed	nal Accounting or maintained t	Services, Inc. to
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Submit form:	Fax: (734) 206- Personal Accou 20500 Eureka R Taylor, MI 481	nting Ser d Suite 1	vices, Inc Employ 12	ver Agent			
	Telephone: (73		100				

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PAS id:				Payroll id:			
Agency id:				Telephone:	Telephone:		
Telephone:							
Service address:							_
City, State, Zip:							_
<u>Service Period:</u> From:	09/16/2020	to	09/30/2020	Due Date:	10/01/2020	Pay Date:	10/15/2020
 Verify the Emplo 	ecessary to process byee days and hours byee has worked the byee has not exceed byee selected the ta byee documented pr	worked schedule the Med sks perfo	e hours authorized icaid service authc rmed				
System I documente above was provided understand that pay	prmation recorded in t of the daily tasks perfo- as face-to-face hours ment will be made ba ts and payment is app	ormed and in accorda sed upon	daily progress\visit ance with my Emplo the Medicaid Service	notes. My signat yers Individual Pla	ture confirms all ho an of Service and Se	ours worked for ervice Authoriza	the service period ation. I
	Er	nployee			-	Date	-
performed as face to pay my employee fo	Representative I have o face services as outli r the Medicaid service funding cannot be use	ned in the es provide	Individual Person C d. I understand that	enter Plan (IPOS) if my employee l	. I authorize Person has not completed	nal Accounting or maintained t	Services, Inc. to
Parti	cipant\Employer\Leg	al or Desi	gnated Representat	ive	_	Date	_
Submit form:	20500 Eureka R	nting Ser d Suite 1	vices, Inc Employ 12	ver Agent			
	Taylor, MI 4818 Telephone: (73		100				

ATTENDANCE INCIDENT REPORT

To be completed and submitted the same day an attendance incident occurred.

Purpose:

To record a missed punch or adjustment of clocking in and out of the Carewhen attendance system and identify the correct clock in and clock out times.

Attendance Incident Reporting:

- 1. Complete Attendance Incident Report fully.
- 2. Both Participant (Employer) and Caregiver (Employee) must sign.
- 3. Fax immediately (734) 206-1436 (Same day of Incident)

Incident Date:		Incident Time:	
Participant\Employer:		Caregiver\Employee:	
PAS Id:		Payroll Id:	
Agency Id:			
Details of Attendance Incid	dent:		
Revised Clock Time in:		Revised Clock Time ou	t:
Tasks Performed: (you ma	y write out tasks performed	or document the task ic	d # as identified in the
attendance system (Carew			
Visit\Progress Note:			
Darticipant\Employer:			Date:
Participant\Employer:			
Caregiver\Employee:			Date:
Caregiver (Employee.			Date.

Attendance Incident Report must be fully completed, incomplete forms will not be processed. Form must be submitted with 24 hours of environmental or participant emergency situations in which you are unable to clock in or out.

If PAS receives this form after processing the current payroll period, there is no guarantee payment will be processed for the period that has been billed. Payment maybe administered on the next payroll cycle.

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PAS Id:		Payroll Id:		
Agency Id:				
Details of Attendance Incid	dent:			
Revised Clock Time in:		Revised Clock Time ou	t:	
Tasks Performed: (you ma	y write out tasks performed	or document the task ic	# as identified in the	
attendance system (Carew	/hen).			
Visit\Progress Note:				
Participant\Employer:			Date:	
Caregiver\Employee:			Date:	

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