#### 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\Employe	er:			Caregiver\E	Employee:			
PAS id:				Payroll id:				
Agency id:		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	
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.								
		nployee			_	Date	-	
As the Employer or Reperformed as face to face to face may my employee for the trainings, Medicaid fur	ace services as outli he Medicaid service ading cannot be used	ned in the is provided d, and it w	Individual Person Ce d. I understand that vill be my responsibili	enter Plan (IPOS) if my employee I ty to make payn	. I authorize Persor has not completed	nal Accounting S or maintained t	Services, Inc. to	
Partici	pant\Employer\Leg	al or Desig	gnated Representati	ve		Date		

Submit form: Fax: (734) 206-1436

Personal Accounting Services, Inc. - Employer Agent

20500 Eureka Rd Suite 112

Taylor, MI 48180

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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\Employ	er:			Caregiver\E	Employee:			
PAS id:		Payroll id: Telephone:		_				
Agency id:	•							
Telephone:					•			
Service address:	•			_				
City, State, Zip:	-						_	
city, state, Lip.			-		-		_	
Service Period:								
From:	07/16/2020	to	07/31/2020	Due Date:	08/01/2020	Pay Date:	08/14/2020	
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.								
		nployee				Date	_	
As the Employer or Re performed as face to f pay my employee for t trainings, Medicaid fur	ace services as outling the Medicaid services	ned in the es provided	e Individual Person Ce ed. I understand that i	nter Plan (IPOS). If my employee h	). I authorize Person has not completed o	nal Accounting S or maintained t	Services, Inc. to	
Partici	pant\Employer\Leg	al or Desi	ignated Representativ	/e	-	Date	_	

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PAS id:				Payroll id:			
Agency id: Telephone:				Telephone:			
				<u> </u>			
Service address:					_		
City, State, Zip:							_
Service Period: From:	08/01/2020	to	08/15/2020	Due Date:	08/16/2020	Pay Date:	09/01/2020
The following is need 1. Verify the Employ 2. Verify the Employ 3. Verify the Employ 4. Verify the Employ 5. Verify the Employ 1. Verify the Employ 1. Verify that the infor	yee days and hours yee has worked the yee has not exceed yee selected the tas	worked schedule the Medi sks perfor ogress\vi	e hours authorized licaid service author rmed risit note		te. Also with clockir	ng in\out in the	Attendance
System I documented above was provided a understand that payn	I the daily tasks perfor as face-to-face hours i nent will be made bas s and payment is appr	ormed and in accorda sed upon t	d daily progress\visit rance with my Employ the Medicaid Service	notes. My signat ers Individual Pla	ture confirms all ho an of Service and Se	urs worked for ervice Authoriza	the service period ation. I
As the Employer or Reperformed as face to pay my employee for trainings, Medicaid fu	epresentative I have r face services as outlir the Medicaid services	reviewed a ned in the es provided	e Individual Person Ce d. I understand that i	enter Plan (IPOS) if my employee l	). I authorize Persor has not completed o	nal Accounting S or maintained t	Services, Inc. to
Partic	ipant\Employer\Lega	al or Desi	gnated Representati	ve	_	Date	_

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PAS id:				Payroll id:	Payroll id:			
Agency id:				 Telephone:	:			
Telephone:								
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City, State, Zip:							_	
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As the Employer or D		nployee	and cortify that you F	manlava ala havra		Date	oro	
As the Employer or Reperformed as face to pay my employee for trainings, Medicaid fu	face services as outli the Medicaid service	ned in the s provide	Individual Person Co	enter Plan (IPOS) if my employee	. I authorize Persor has not completed	nal Accounting to or maintained t	Services, Inc. to	
Partic	ipant\Employer\Leg	al or Desig	gnated Representati	ve	_	Date	_	

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PAS id:		Payroll id: Telephone:					
Agency id:							
Telephone:							
Service address:							_
City, State, Zip:							_
<u>Service Period:</u> From:	09/01/2020	to	09/15/2020	Due Date:	09/16/2020	Pay Date:	10/01/2020
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training requirements a		nployee			_	Date	-
As the Employer or Rep			and certify that my E	mployee's hours	recorded in the Att		m were
performed as face to fa pay my employee for th trainings, Medicaid fun	ne Medicaid service	s provided	l. I understand that i	if my employee l	has not completed	or maintained t	
Particip	oant\Employer\Leg	al or Desig	nated Representation	ve	_	Date	-

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PAS id: Agency id: Telephone:				Payroll id:	Payroll id:		
				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
The following is ned 1. Verify the Employ 2. Verify the Employ 3. Verify the Employ 4. Verify the Employ 5. Verify the Employ	yee days and hours yee has worked the yee has not exceed yee selected the tas yee documented pro	worked e schedule the Medi sks perfor rogress\vi	e hours authorized licaid service autho rmed risit note	orization	e Also with clockin	og in\out in the	Attendance
System I documented above was provided a understand that paym training requirements	I the daily tasks perfor as face-to-face hours i nent will be made bas s and payment is appr	ormed and in accorda sed upon t	d daily progress\visit in ance with my Employ the Medicaid Service	notes. My signat yers Individual Pla	ture confirms all ho an of Service and Se	urs worked for ervice Authoriza	the service period ation. I
As the Employer or Re performed as face to to pay my employee for trainings, Medicaid fu	face services as outlir the Medicaid services	ned in the es provided	e Individual Person Co d. I understand that	enter Plan (IPOS). if my employee h	). I authorize Persor has not completed o	nal Accounting to maintained t	Services, Inc. to
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#### 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	lent:			
Device d Clark Time in	Davis and Clark Times and			
Revised Clock Time in:	Revised Clock Time out:		C: 1: .1	
	y write out tasks performed or document the task id #	as identi	fied in the	
attendance system (Carew	nen).			
Visit\Progress Note:				
VISIT (FTOGTESS NOTE.				
Participant\Employer:		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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Incident Date:		Incident Time:		
Participant\Employer:		Caregiver\Employee:		
PAS Id:		Payroll Id:		
Agency Id:				
Details of Attendance Incid	dent:			
Davisa d Clark Times in	<u> </u>	Davisa d Clask Times and	<u>.</u> .	
Revised Clock Time in:		Revised Clock Time out		Carl tarillar
	y write out tasks performed	or document the task id	i # as identi	fled in the
attendance system (Carew	nen).			
Visit\Progress Note:				
Tiole (Frogress Hotel				
Participant\Employer:			Date:	
Caregiver\Employee:			Date:	

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