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: |
| System I documented the daily tasks performance above was provided as face-to-face hours understand that payment will be made bast training requirements and payment is app | worked e schedule hour the Medicaid s sks performed rogress\visit no he Attendance S ormed and daily p in accordance w sed upon the Me roved by the Fur | rs authorized service authorization ote ystem is accurate and complete. Also with clocki progress\visit notes. My signature confirms all ho with my Employers Individual Plan of Service and S edicaid Service Authorization, recorded hours from | ours worked for the service period service Authorization. I m the Attendance System, |
| | nployee reviewed and ce | rtify that my Employee's hours recorded in the At | Date ttendance System were |
| performed as face to face services as outli pay my employee for the Medicaid service | ned in the Indivi es provided. I un | dual Person Center Plan (IPOS). I authorize Perso derstand that if my employee has not completed my responsibility to make payment to my Employ | onal Accounting Services, Inc. to or maintained the required |
| Participant\Employer\Leg | al or Designated | Representative | Date |

Submit form: Fax: (734) 720-1002

Personal Accounting Services, Inc. - Employer Agent

20500 Eureka Rd Suite 112

Taylor, MI 48180

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: |
| System I documented the daily tasks performance above was provided as face-to-face hours understand that payment will be made bast training requirements and payment is app | worked e schedule hour the Medicaid s sks performed rogress\visit no he Attendance S ormed and daily p in accordance w sed upon the Me roved by the Fur | rs authorized service authorization ote ystem is accurate and complete. Also with clocki progress\visit notes. My signature confirms all ho with my Employers Individual Plan of Service and S edicaid Service Authorization, recorded hours from | ours worked for the service period service Authorization. I m the Attendance System, |
| | nployee reviewed and ce | rtify that my Employee's hours recorded in the At | Date ttendance System were |
| performed as face to face services as outli pay my employee for the Medicaid service | ned in the Indivi es provided. I un | dual Person Center Plan (IPOS). I authorize Perso derstand that if my employee has not completed my responsibility to make payment to my Employ | onal Accounting Services, Inc. to or maintained the required |
| Participant\Employer\Leg | al or Designated | Representative | Date |

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Taylor, MI 48180

Purpose:

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| Participant\Employer: | | Caregiver\Employee: | | |
|---|---|---|--|--------------------------------|
| PAS id: | | Payroll id: | | |
| Agency id: | | Telephone: | | |
| Telephone: | | | | |
| Service address: | | | | _ |
| City, State, Zip: | | | | - |
| Service Period: | | | | 11/29/24 |
| From: | to | Due Date: | Pay Date: | 11/47/44 |
| The following is necessary to process at 1. Verify the Employee days and hours 2. Verify the Employee has worked the 3. Verify the Employee has not exceed 4. Verify the Employee selected the tas 5. Verify the Employee documented pr | worked schedule hours a the Medicaid serv sks performed ogress\visit note | uthorized | ng in\out in the | Attendance |
| System I documented the daily tasks perfo above was provided as face-to-face hours i | rmed and daily prog in accordance with sed upon the Medic | gress\visit notes. My signature confirms all ho my Employers Individual Plan of Service and S aid Service Authorization, recorded hours fron | ours worked for t service Authoriza | the service period ition. I |
| | nployee | | Date | - |
| performed as face to face services as outlin pay my employee for the Medicaid service | ned in the Individua s provided. I under | y that my Employee's hours recorded in the At al Person Center Plan (IPOS). I authorize Perso rstand that if my employee has not completed responsibility to make payment to my Employ | nal Accounting S or maintained th | Services, Inc. to |
| Participant\Employer\Lega | al or Designated Re | epresentative | Date | - |

Submit form: Fax: (734) 720-1002

Personal Accounting Services, Inc. - Employer Agent

20500 Eureka Rd Suite 112

Taylor, MI 48180

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\E | mployee: | | |
|---|--|----------------------------------|--|--|--------------------------------------|--------------------------------|
| PAS id: | | | Payroll id: | | | |
| Agency id: | | | Telephone: | | | |
| Telephone: | | | _ | | | |
| Service address: | | | | | | _ |
| City, State, Zip: | | | | | | - |
| Service Period: | | | | 12/01/24 | | 12/13/24 |
| From: | to | | Due Date: | 12/01/24 | Pay Date: | 12/13/24 |
| 1. Verify the Employee days and hours 2. Verify the Employee has worked the 3. Verify the Employee has not exceed 4. Verify the Employee selected the tas 5. Verify the Employee documented pr I certify that the information recorded in the System I documented the daily tasks perfor above was provided as face-to-face hours understand that payment will be made base. | e schedule hours a the Medicaid ser sks performed rogress\visit note he Attendance Syst ormed and daily pro in accordance with | tem is accurate ogress\visit not | and complete es. My signatu Individual Pla | ure confirms all ho in of Service and S | ours worked for Service Authoriza | the service period ation. I |
| training requirements and payment is app | roved by the Fundi | ng Agency. | | | | |
| Er | mployee | | | _ | Date | - |
| As the Employer or Representative I have I | reviewed and certif | fy that my Emp | loyee's hours | recorded in the At | tendance Syster | m were |
| performed as face to face services as outli | | | , , | | J | • |
| pay my employee for the Medicaid service trainings, Medicaid funding cannot be used | • | | | • | | he required |
| trainings, Medicala randing carrier be asce | a, and it will be my | responsibility | o make paym | ient to my employ | cc. | |
| Participant\Employer\Leg | al or Designated R | epresentative | | _ | Date | - |

Submit form: Fax: (734) 720-1002

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20500 Eureka Rd Suite 112

Taylor, MI 48180

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: | | | <u> </u> | | |
| Service address: | | | | | |
| City, State, Zip: | | | | | _ |
| Service Period: | | | | | |
| From: | to | 12/15/24 | Due Date: | Pay Date: | 12/31/2024 |
| The following is necessary to process at 1. Verify the Employee days and hours 2. Verify the Employee has worked the 3. Verify the Employee has not exceed 4. Verify the Employee selected the tas 5. Verify the Employee documented pr | worked schedule the Media sks perfori ogress\vis | e hours authorized caid service auth med sit note | orization | ng in\out in the | Attendance |
| System I documented the daily tasks perfo above was provided as face-to-face hours i understand that payment will be made bas training requirements and payment is appr | rmed and on the cordanged on the cordang | daily progress\visit nce with my Emplo he Medicaid Servic | t notes. My signature confirms all ho oyers Individual Plan of Service and Se ce Authorization, recorded hours from | urs worked for ervice Authoriza | the service period ation. I |
| En | nployee | | | Date | |
| As the Employer or Representative I have reperformed as face to face services as outling pay my employee for the Medicaid service trainings, Medicaid funding cannot be used | ned in the s s provided | Individual Person (| Center Plan (IPOS). I authorize Persor it if my employee has not completed o | nal Accounting or maintained t | Services, Inc. to |
| Participant\Employer\Lega | al or Desig | nated Representa | tive | Date | _ |

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|---|---|---|--|
| PAS id: | | Payroll id: | |
| Agency id: | | Telephone: | |
| Telephone: | | | |
| Service address: | | | |
| City, State, Zip: | | | |
| | | | |
| Service Period: | | | |
| From: | to | Due Date: | Pay Date: |
| System I documented the daily tasks performance above was provided as face-to-face hours understand that payment will be made bast training requirements and payment is app | worked e schedule hour the Medicaid s sks performed rogress\visit no he Attendance S ormed and daily p in accordance w sed upon the Me roved by the Fur | rs authorized service authorization ote ystem is accurate and complete. Also with clocki progress\visit notes. My signature confirms all ho with my Employers Individual Plan of Service and S edicaid Service Authorization, recorded hours from | ours worked for the service period service Authorization. I m the Attendance System, |
| | nployee reviewed and ce | rtify that my Employee's hours recorded in the At | Date ttendance System were |
| performed as face to face services as outli pay my employee for the Medicaid service | ned in the Indivi es provided. I un | dual Person Center Plan (IPOS). I authorize Perso derstand that if my employee has not completed my responsibility to make payment to my Employ | onal Accounting Services, Inc. to or maintained the required |
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