

## 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).

<b>Participant\Employer:</b> _____	<b>Caregiver\Employee:</b> _____
<b>PAS id:</b> _____	<b>Payroll id:</b> _____
<b>Agency id:</b> _____	<b>Telephone:</b> _____
<b>Telephone:</b> _____	
<b>Service address:</b> _____	
<b>City, State, Zip:</b> _____	
<b>Service Period:</b>	
<b>From:</b> _____	<b>to</b> _____
<b>Due Date:</b> _____	<b>Pay Date:</b> _____
<p>I the Employer have reviewed the following before signing the Employer Pay Authorization Form: <b>The following is necessary to process a Medicaid Claim.</b></p> <ol style="list-style-type: none"><li>1. Verify the Employee days and hours worked</li><li>2. Verify the Employee has worked the schedule hours authorized</li><li>3. Verify the Employee has not exceed the Medicaid service authorization</li><li>4. Verify the Employee selected the tasks performed</li><li>5. Verify the Employee documented progress\visit note</li></ol>	
<p>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.</p>	
_____ <b>Employee</b>	_____ <b>Date</b>
<p>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.</p>	
_____ <b>Participant\Employer\Legal or Designated Representative</b>	_____ <b>Date</b>

**Submit form:**

**Fax: (734) 206-1440**

Personal Accounting Services, Inc. - Employer Agent  
20500 Eureka Rd Suite 112  
Taylor, MI 48180  
Telephone: (734) 729-3100

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<b>City, State, Zip:</b> _____	
<b>Service Period:</b>	
<b>From:</b> _____	<b>to</b> _____ <b>Due Date:</b> _____ <b>Pay Date:</b> <u>11/29/24</u>
<p>I the Employer have reviewed the following before signing the Employer Pay Authorization Form: <b>The following is necessary to process a Medicaid Claim.</b></p> <ol style="list-style-type: none"><li>1. Verify the Employee days and hours worked</li><li>2. Verify the Employee has worked the schedule hours authorized</li><li>3. Verify the Employee has not exceed the Medicaid service authorization</li><li>4. Verify the Employee selected the tasks performed</li><li>5. Verify the Employee documented progress\visit note</li></ol>	
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<b>Service address:</b> _____	
<b>City, State, Zip:</b> _____	
<b>Service Period:</b>	
<b>From:</b> _____	<b>to</b> _____ <b>Due Date:</b> _____ <b>Pay Date:</b> <u>12/13/24</u>
<p>I the Employer have reviewed the following before signing the Employer Pay Authorization Form: <b>The following is necessary to process a Medicaid Claim.</b></p> <ol style="list-style-type: none"><li>1. Verify the Employee days and hours worked</li><li>2. Verify the Employee has worked the schedule hours authorized</li><li>3. Verify the Employee has not exceed the Medicaid service authorization</li><li>4. Verify the Employee selected the tasks performed</li><li>5. Verify the Employee documented progress\visit note</li></ol>	
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<b>From:</b> _____	<b>to</b> <u>12/15/24</u> <b>Due Date:</b> _____ <b>Pay Date:</b> <u>12/31/24</u>
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