# 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:** 01/01/25 to 01/15/25 **Due Date:** 01/16/25 **Pay Date:** 02/01/25

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
20500 Eureka Rd Suite 112
Taylor, MI 48180
Telephone: (734) 729-3100

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| **PAS id:** | | **Payroll id:** | |
| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** 01/16/25 to 01/31/25 **Due Date:** 02/01/25 **Pay Date:** 02/15/25

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| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** 02/01/25 to 02/15/25 **Due Date:** 02/16/25 **Pay Date:** 03/01/25

I the Employer have reviewed the following before signing the Employer Pay Authorization Form:
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| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** 02/16/25 to 02/28/25 **Due Date:** 03/01/25 **Pay Date:** 03/15/25

I the Employer have reviewed the following before signing the Employer Pay Authorization Form:
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| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** 03/01/25 to 03/15/25 **Due Date:** 03/16/25 **Pay Date:** 04/01/25

I the Employer have reviewed the following before signing the Employer Pay Authorization Form:
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| **Participant\Employer:** | | **Caregiver\Employee:** | |
| **PAS id:** | | **Payroll id:** | |
| **Agency id:** | | **Telephone:** | |
| **Telephone:** | | | |
| **Service address:** | | | |
| **City, State, Zip:** | | | |

**Service Period:**
**From:** 03/16/25 to 03/31/25 **Due Date:** 04/01/25 **Pay Date:** 04/15/25

I the Employer have reviewed the following before signing the Employer Pay Authorization Form:
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20500 Eureka Rd Suite 112
Taylor, MI 48180
Telephone: (734) 729-3100

Personal Accounting Services, Inc.
An AssuranceSD family company

***Personal Accounting Services, Inc.***
*20500 Eureka Road Suite 112 | Taylor, MI 48180*
*Phone (734) 729-3100 | Fax (734) 206-1433*

# Address Change Request/Notification Form

***Please Check One** **Employee** ☐ **Employe** ☐

**Full Name** _____

**PK2yŜ bdzY ōŜ** _____

**Email** _____

**hfŘ Address** _____

**New Address** _____

**Reason** _____

_____

_____

**Today's Date** _____ **Change Effective Date** _____

**Signature** _____

***Return to the HR Department (HR Fax: 734.206.1433, HR Email: HR@1-pas.com)**

***Please note: Employees/Employers are responsible for informing Personal Accounting Services, Inc. of any changes in personal information including address, phone number, and email address, etc.**

# Direct Care Professionals In need

On behalf of Individual and families we support we are seeking to establishing a database for Caregivers who would like to obtain additional hours. This listing will be made available to Individuals and families.

If you would like to participate please provide the following:

| | |
|---|---|
| Name: | |
| Phone Number: | |
| Email Address: | |

By signing this form, your authorization allows use to share your basic information to individuals and families looking for Caregivers.

Signature: _____ Date: _____

Personal Accounting Services, Inc.

An AssuranceSD family company

Personal Accounting Services, Inc.

An AssuranceSD family company

**Pay Schedule**
**Fiscal Year 2024-2025**

**Direct Hire Support Staff**
**Semi Monthly Pay Schedule**

| Pay Date | Pay Period |
|---|---|
| 11/01/2024 | 10/01/2024-10/15/2024 |
| 11/15/2024 | 10/16/2024-10/31/2024 |
| 11/29/2024* | 11/01/2024-11/15/2024 |
| 12/13/2024* | 11/16/2024-11/30/2024 |
| 12/31/2024* | 12/01/2024-12/15/2024 |
| 01/15/2025 | 12/16/2024-12/31/2024 |
| 01/31/2025* | 01/01/2025-01/15/2025 |
| 02/14/2025* | 01/16/2025-01/31/2025 |
| 02/28/2025* | 02/01/2025-02/15/2025 |
| 03/14/2025* | 02/16/2025-02/28/2025 |
| 04/01/2025 | 03/01/2025-03/15/2025 |
| 04/15/2025 | 03/16/2025-03/31/2025 |
| 05/01/2025 | 04/01/2025-04/15/2025 |
| 05/15/2025 | 04/16/2025-04/30/2025 |
| 05/30/2025* | 05/01/2025-05/15/2025 |
| 06/13/2025* | 05/16/2025-05/31/2025 |
| 07/01/2025 | 06/01/2025-06/15/2025 |
| 07/15/2025 | 06/16/2025-06/30/2025 |
| 08/01/2025 | 07/01/2025-07/15/2025 |
| 08/15/2025 | 07/16/2025-07/31/2025 |
| 09/01/2025 | 08/01/2025-08/15/2025 |
| 09/15/2025 | 08/16/2025-08/31/2025 |
| 10/01/2025 | 09/01/2025-09/15/2025 |
| 10/15/2025 | 09/16/2025-09/30/2025 |

***If the pay date falls on a Saturday or Sunday, payroll will be processed on Friday.**

***If the pay date falls on a Holiday, Payroll will be processed on the prior business day.**