Personal Accounting Services, Inc.
Part of the AssuranceSD Family

2024 - 2025 PAYROLL SCHEDULE

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**.

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EMPLOYER PAY AUTHORIZATION

Purpose

This form is used for Participant\Employer to authorize payment to their Direct Care Professional (DCP)\Employee which attests that a review of hours recorded through the attendance system is accurate and in accordance with the Individual Person of Service (IPOS).

Participant/Employer: _____ DCP/Employee: _____

PAS ID: _____ Payroll ID: _____

Agency ID: _____ Telephone: _____

Telephone: _____

Service Address: _____

City, State, Zip: _____

Service Period

From: 07/01/2025 **to** 07/15/2025 **Due Date:** 07/16/2025 **Pay Date:** 08/01/2025

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 exceeded 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.

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Direct Care Professional/Employee Signature **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 Signature **Date**

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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DIRECT CARE PROFESSIONALS IN NEED

On behalf of Individual and families we support, we are seeking to establishing a database for Direct Care Professionals who would like to obtain additional hours. This list 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 us to share your basic information to individuals and families looking for Direct Care Professionals.

Signature: _____ Date: _____

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ADDRESS CHANGE REQUEST/NOTIFICATION FORM

Please check one:

☐ Direct Care Professional (Employee)

☐ Participant (Employer)

Full Name: _____

Phone Number: _____ Email Address: _____

Old Address: _____

New Address: _____

Reason:

Effective Date: _____

Signature: _____ Date: _____

Return to the HR Department:

- **Fax:** 734.206.1433
- **Email:** HR@PASselfdirection.com

Note:

Direct Care Professionals/Participants are responsible for informing PAS - Personal Accounting Services, Inc. - of any changes in personal information including address, phone number, and email address, etc.