Personal Accounting Services, Inc.
Part of the AssuranceSD Family

RATE CHANGE FORM

Direct Care Professional Name: _____

Participant Name: _____

Authorized Representative/Legal Guardian Name: _____

Service Code and Modifiers	Current Rate of Pay	New Rate of Pay	Effective Date of Change

By signing this agreement, I acknowledge that the rate of pay listed on this form will be effective on the date listed above or the date this is submitted to Personal Accounting Services (PAS), whichever is later.

I understand that this rate of pay supersedes all previous rates of pay and will be in effect until a change of rate form is submitted.

I understand that this rate change will not be applied to dates of service already paid.

Retroactive payments or payment adjustments will not be made.

It is the Participant/Employer's responsibility to ensure this form is submitted timely.

Direct Care Professional Signature: _____ Date: _____

Participant: _____ Date: _____

or

Authorized Representative/Legal Guardian Signature: _____ Date: _____

Upon completion, return this form to: **hr@passelfdirection.com**