Personal Accounting Services, Inc.
Part of the AssuranceSD Family

CLS/WAYNE DIRECT CARE WORKER ENROLLMENT INFORMATION

PARTICIPANT INFORMATION: (Please include information as it appears on Social Security Card)

Participant Full Name: _____

Participant Program: CLS Wayne/DWIHN Support Coordinator Name: _____

Legal or Authorized Representative Name (if applicable): _____

Mailing Address: _____

Physical Address *(if different)*: _____

Date of Birth: _____ Social Security Number: _____ County: _____

Phone Number: _____ Email Address: _____

DIRECT CARE WORKER INFORMATION

Direct Care Worker: _____

Mailing Address: _____

Physical Address (if different): _____

Date of Birth: _____ Home Phone *(Optional)*: _____ Mobile Phone: _____

Email Address: _____ Social Security Number: _____

Driver's License/State ID #: _____ Driver's License/State ID Expiration Date: _____

REQUIREMENT STATEMENTS

I understand that prior to starting work, I must pass a Criminal Background Check. A Criminal Background Check will be completed annually following my start date. If during any Criminal Background Check, disqualifying convictions are found, I understand I will be terminated from providing services to the participant listed in this agreement.

I understand that prior to receiving a start date, I must complete the required paperwork and IPOS training.

I understand that I may not begin providing services or submitting time until I receive a start date. I understand that any time worked before my official start date will not be reimbursed.

I understand that I can only be paid for budgeted and authorized weekly hours.

(continued on next page)

REQUIREMENT STATEMENTS *(continued)*

I understand that I will not be paid for hours not submitted, not approved by my employer, or hours that are unauthorized.

I understand that my employer may provide employer specific training.

I understand that PAS (Personal Accounting Services) is not my employer and the individual or legal representative I support is my employer.

By signing below, I attest to my understanding of the above statements and certify that all information provided is true and accurate to the best of my knowledge.

Direct Care Worker Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____