Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER ORIENTATION

Direct Care Worker Full Name: _____

Participant Full Name: _____

REVIEW

1. Employment Application.
2. Direct Care Worker Relationship Attestation.
3. Employment Agreement: Participant is the Employer.
4. Medicaid Provider Agreement: PAS bills the insurance to pay the Employee.
5. Training Acknowledgement of Required Trainings & Documentation.
6. Mileage Reimbursement Requirements/Only if Authorized: Must have current Auto Insurance & Registration on file.
7. We cannot make payment without active authorization or above the authorized amount. Never work before a start date is provided.
8. For billing questions regarding a payment you received, please call: **734.729.3100**.
9. For payroll questions regarding a missed payment, please call: **734.729.3100**.
10. Employee Start Date: _____
    Determined by completion of requirements and agency approval/active authorizations.
11. Pay Period Schedule.
12. Billing Forms: Provided on initial hire; also located on website at: www.PASSelfDirection.com
    a. EPA - Employer Pay Authorization: Backup documentation for time worked and logged in Assuricare CareWhen
    b. AIR - Attendance Incident Report: Limitations Apply: Must be submitted within 24 hours of the attendance incident. Failure to provide documentation timely may result in payment delay.
    c. PVN - Progress Note: Restrictions Apply
13. Assuricare CareWhen Attendance System (free APP) with GPS.
    Your enrollment specialist will ensure you are able to clock in successfully for the first time. We are available to help over Teams, our office, or by phone. If you have additional questions about EVV, contact our dedicated EVV team at: **734.729.3100**.
    a. *Assuricare CareWhen* is a free mobile app.
    b. Step-by-Step instructions will be provided to you.
14. PAS Contact List.
15. Overview of Program Rules and Requirements.
16. Reporting of Incident(s): Medicaid Fraud / Accident / Hospital / Protective Services / Recipient Rights.
17. False Claim Act (FCA).

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By signing below:

I acknowledge that I have reviewed and received a copy of the above information.

I understand the requirements as provided to me.

I will not hold PAS responsible for hours worked that have not been submitted, approved by my employer, or that are unauthorized.

Direct Care Worker Signature: _____ Date: _____

Participant/Employer Signature: _____ Date: _____