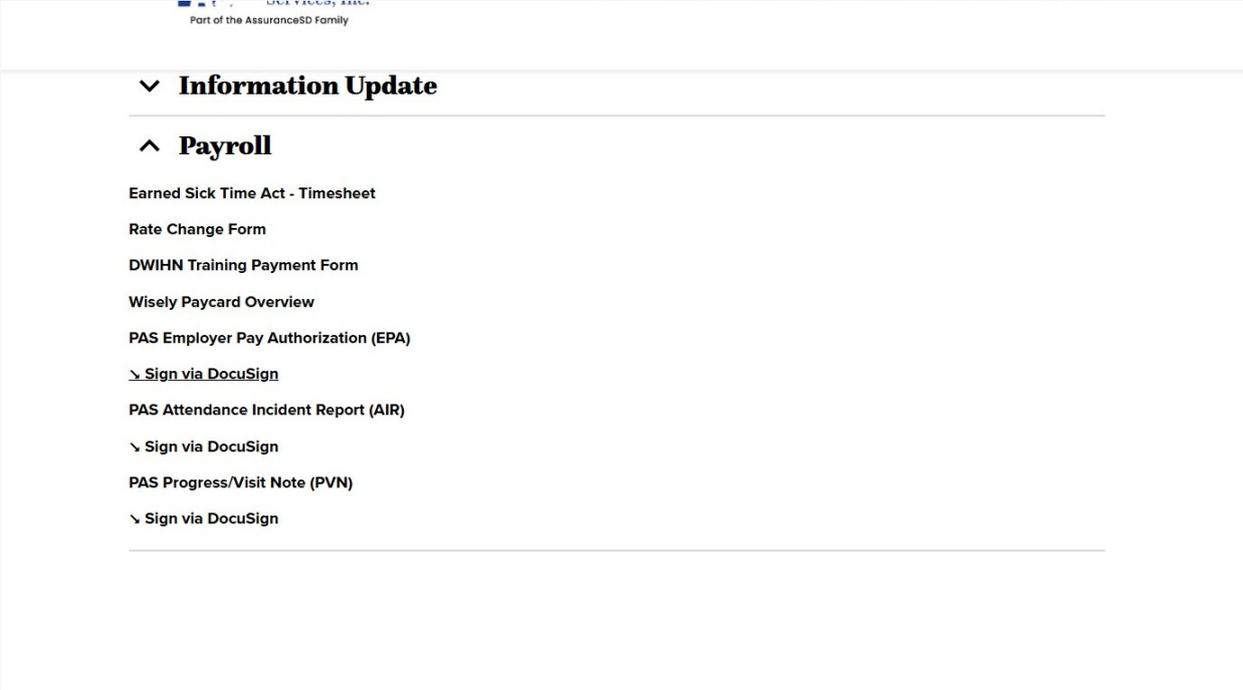


Sign Documents Using DocuSign

1 Navigate to <https://passelfdirection.com/forms/>



2

Click "\ Sign via DocuSign" for the form you want to complete and submit.

∨ **Information Update**

∧ **Payroll**

Earned Sick Time Act - Timesheet

Rate Change Form

DWIHN Training Payment Form

Wisely Paycard Overview

PAS Employer Pay Authorization (EPA)

∨ Sign via DocuSign

PAS Attendance Incident Report (AIR)

∨ Sign via DocuSign

PAS Progress/Visit Note (PVN)

∨ Sign via DocuSign



Tip! The Employee will most commonly start the form. The Employee's information should always be entered first and the Employee should always sign first.

3 Click the "Full Name" field.

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *
Full Name

Your Email: *
Email Address

Please provide information for any other signers needed for this document.

Participant-Employer

Name:
Full Name

Email:
Email Address

4 Enter the name of the employee. The employee is the first signer.

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *
Jelly Bean

Your Email: *
Email Address

Please provide information for any other signers needed for this document.

Participant-Employer

Name:
Full Name

Email:
Email Address

5 Click the "Email Address" field.

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

6 Enter the email address of the employee.

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

7 Click the "Full Name" field.

PAS Personal Accounting Services, Inc. Begin Signing [help](#)

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

8 Enter the name of the Participant or Employer. This should be the second signer.

PAS Personal Accounting Services, Inc. Begin Signing [help](#)

PowerForm Signer Information

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer.
Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

Begin Signing

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9

Click the "Email Address" field.

Fill in the name and email for each signing role listed below.

The first signer should be the employee, and the second signer should be the participant or employer. Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

Begin Signing

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10

Enter the email address for the Participant or Employer to receive a copy of the form to sign.

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer. Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

Begin Signing

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11

Click "Begin Signing"

Fill in the name and email for each signing role listed below.
The first signer should be the employee, and the second signer should be the participant or employer. Signers will receive an email inviting them to sign this document.

Please enter your name and email to begin the signing process.

Employee

Your Name: *

Your Email: *

Please provide information for any other signers needed for this document.

Participant-Employer

Name:

Email:

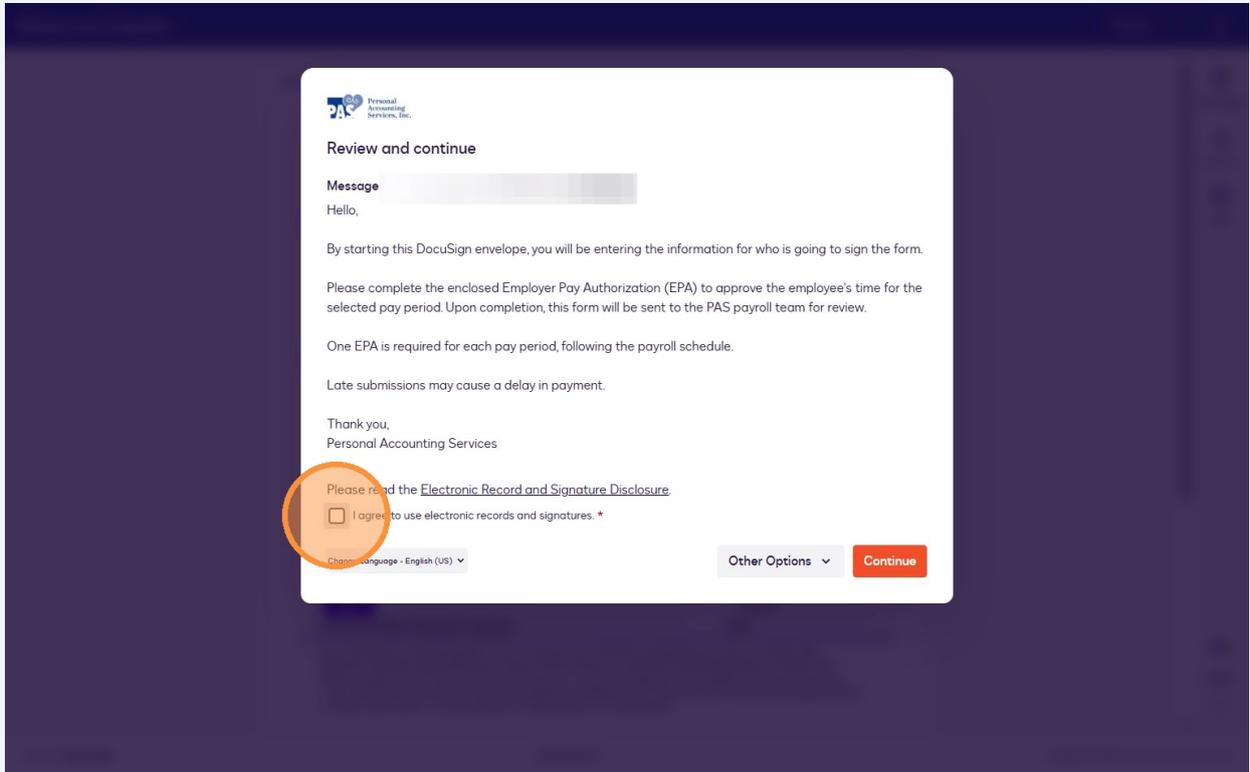
Begin Signing

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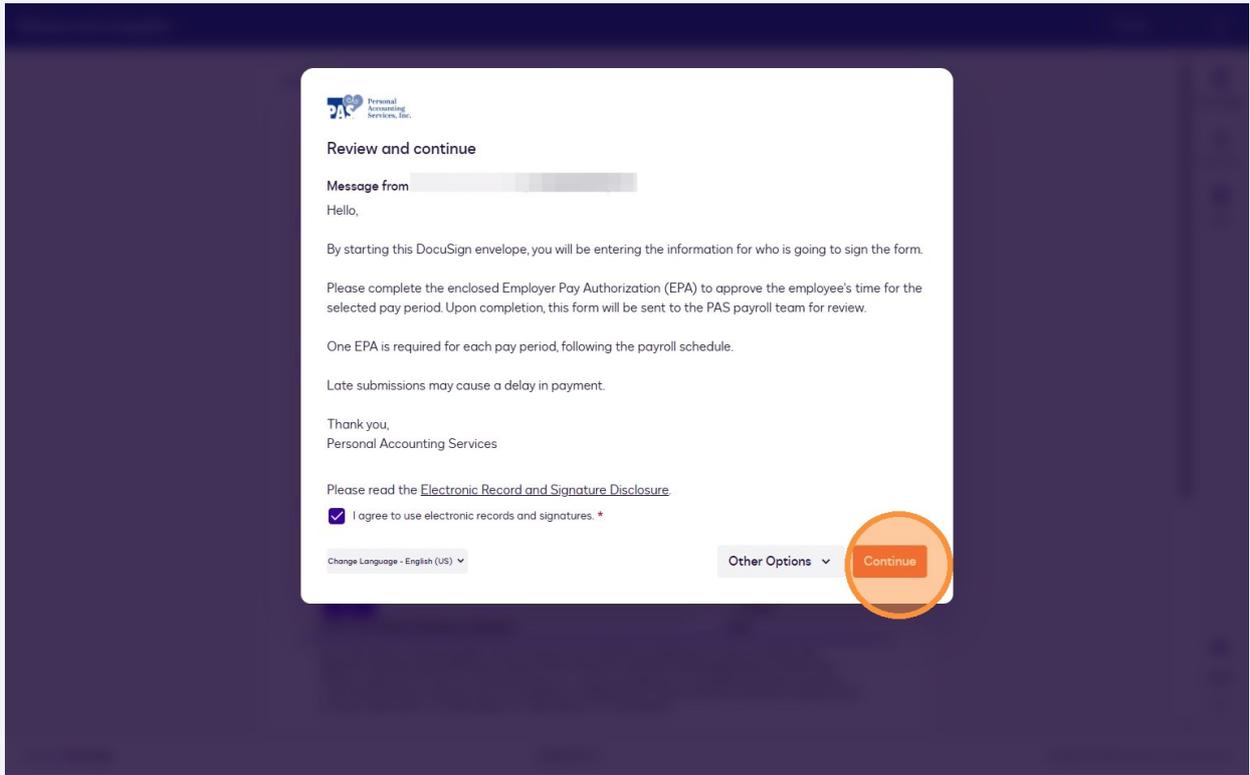
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12 Click "I agree to use electronic records and signatures."



13 Click "Continue"



14 Click the first "Required" field or Start.

Review and complete



15

Enter the correct information in all required fields. Then, click "Sign".

Purpose
This form is used for Participant/Employer to authorize payment to their Direct Care Worker (DCW)/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:	Candy Cane	DCW/Employee:	Jelly Bean
PAS ID:		Payroll ID:	
Agency ID:		Telephone:	4445557878
Telephone:	5558887979		
Service Address:	123 Candy Cane Lane		
City, State, Zip:	Candy City, Sweet State, 12345		

Service Period
From: 01/05/2026 to 01/16/2026 Due Date: Pay Date:

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 Employer's 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 approved by the Funding Agency.

 _____ 1/9/2026
Direct Care Worker/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.

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Review the signature options. Once you have selected a signature, click "Adopt and Sign".

Full Name* Jelly Bean Initials* JB

SELECT STYLE DRAW USE SIGNATURE PAD UPLOAD

PREVIEW Change Style

Signed by:  Initial: 
97D47C36589948A...

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts.

 CANCEL

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 Employer's 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 approved by the Funding Agency.

 _____ 1/9/2026
Direct Care Worker/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.

17 Click "Finish".

If there is any information missing, the form will not allow you to complete it.

DocuSign Envelope ID: 1DC6C86A-7841-4613-8C86-BA433ECF22F6

PAS Personal Accounting Services, Inc.
Part of the AssuranceSD Family

EMPLOYER PAY AUTHORIZATION

Purpose
This form is used for Participant/Employer to authorize payment to their Direct Care Worker (DCW)/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: Candy Cane DCW/Employee: Jelly Bean
PAS ID: _____ Payroll ID: _____
Agency ID: _____ Telephone: 4445557878
Telephone: 5558887979
Service Address: 123 Candy Cane Lane
City, State, Zip: Candy City, Sweet State, 12345

Service Period
From: 01/05/2026 to 01/16/2026 Due Date: _____ Pay Date: _____

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 Employer's Individual Plan of Service and Service Authorization. I understand that payment will be made based on the Medicaid Service Authorization, recorded hours from the Attendance System, training requirements and payment is approved by the Funding Agency.

Jelly Bean 1/9/2026

100%

18 Decide if you want to download or print a copy. Then, you can select 'Close'.

Please note, DocuSign will automatically email you a completed copy of the document for your records.

Save a copy of your document

Your document has been signed

Select **Download** to save this document to your device or **Print** for a paper copy.

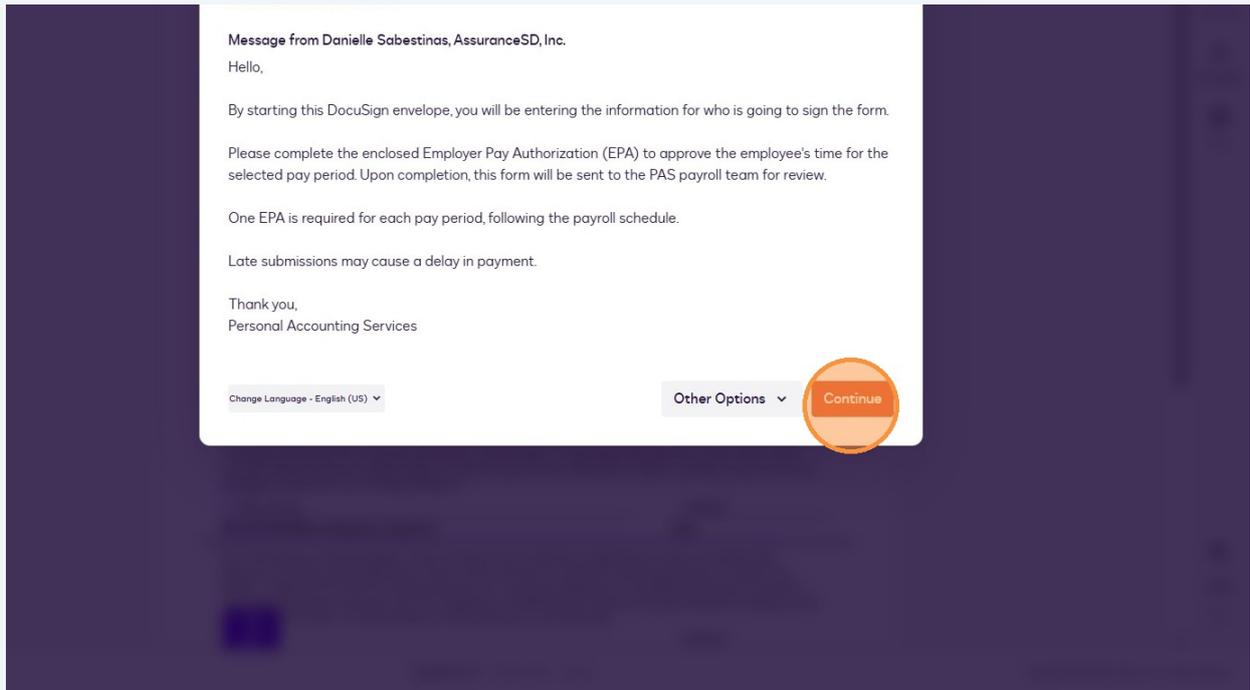
DOWNLOAD **PRINT** **CLOSE**



Tip! After the Employee "Finishes" the form, it will automatically be emailed to the Participant or Employer using the information entered in the first step.

19

Once the Participant or Employer selects the link they received via email, click "Continue".



21

If the details entered by the Employee are accurate and you approve them, click 'Sign'.

Service Address: 123 Candy Cane Lane
 City, State, Zip: Candy City, Sweet State, 12345

Service Period
From: 01/05/2026 **to** 01/16/2026 **Due Date:** _____ **Pay Date:** _____

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 Employee's 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.

Jelly Bran _____ 1/9/2026
Direct Care Worker/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.

Jelly Bran _____ 1/9/2026
Participant/Employer Signature **Date**

Please submit form via the following options:

Fax	Email
734.720.1002 (DWHN)	ab@passelfdirection.com
734.206.1440 (All Other Agencies)	

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After signing, click "Finish".

Employer's 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.

Jelly Bran _____ 1/9/2026
Direct Care Worker/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.

Candy Cane _____ 1/9/2026
Participant/Employer Signature **Date**

Please submit form via the following options:

Fax	Email
734.720.1002 (DWHN)	ab@passelfdirection.com
734.206.1440 (All Other Agencies)	

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1 of 1



Ready to Finish?

You've completed the required fields. Review your work, then select Finish.

Finish

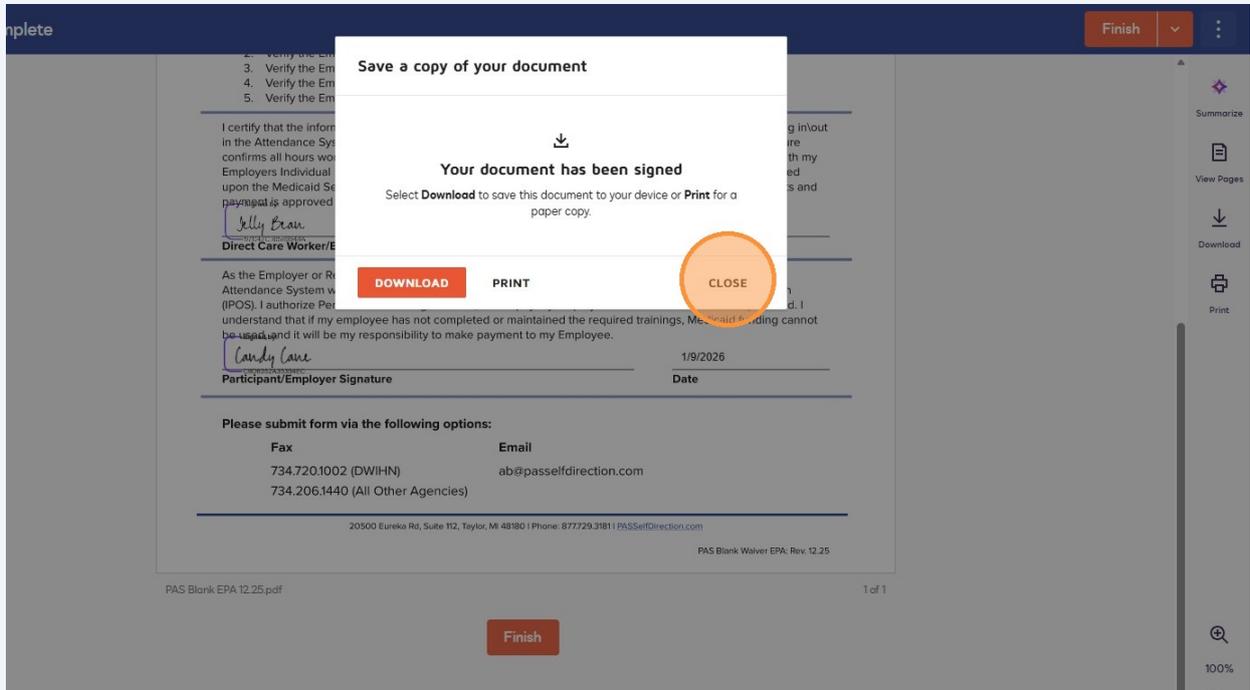
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23 You can download or print the form, or click "Close".

Please note, the completed document will automatically be emailed to you for your records.



i Tip! The completed form will automatically be sent to the PAS payroll team for review and processing. If you completed the form using DocuSign, you do not need to email, fax or mail it to us!