Personal Accounting Services, Inc.
Part of the AssuranceSD Family

DIRECT CARE WORKER
ST. CLAIR COUNTY CMH
PRE-EMPLOYMENT TRAINING PAYMENTS

Participant/Employer Full Name: _____

Direct Care Worker/Employee Full Name: _____

Submission Date: _____

PARTICIPANT/EMPLOYER STATEMENTS

By submitting this form, I certify that my Direct Care Worker/Employee has completed the trainings listed below. By signing this form, I attest that my worker has completed the required training and submitted documentation of completion to Personal Accounting Services.

I understand that my Direct Care Worker/Employee will be reimbursed at the training rate of pay multiplied by the number of eligible training hours completed.

Training hours were allocated by St. Clair County CMH and are a set amount.

I understand that my Direct Care Worker/Employee will be paid for the pre-employment training:

☐ With their first paycheck (for new Participants/Employers).

☐ In an off-cycle payment (for existing Participants/Employers).

I understand that payment will be delayed if proof of training completion has not been provided to Personal Accounting Services.

I understand that the pre-employment training payment is a one-time payment.

Hourly Rate of Pay: $15 per hour.

Training Hours: 4.5 hours total is the maximum number of hours eligible.

TRAINING	NUMBER OF ALLOCATED HOURS	ELIGIBLE FOR PAYMENT (PAS USE ONLY)
First Aid	15 minutes	
Recipient Rights in Person	3.5 hours	
Recipient Rights Refresher Test	1 hour	
Universal Precautions	15 minutes	
Emergency Preparedness	15 minutes	
IPOS Training	15 minutes	

Total eligible training hours to be paid: _____

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DIRECT CARE WORKER/EMPLOYEE STATEMENTS

By signing this document requesting payment for pre-employment training, I certify that I have completed the trainings listed above. I have provided proof of training completion to PAS.

I understand that failure to provide proof of training completion will delay my training payment.

I understand that the training payment is considered taxable income.

I understand that I will not be paid for trainings by Personal Accounting Services if they were taken previously with another employer. PAS will identify the trainings I am eligible for payment for.

Direct Care Worker/Employee Full Name: _____

_____ _____

Direct Care Worker/Employee Signature Date

Participant/Employer Full Name: _____

_____ _____

Participant/Employer Signature Date