EMPLOYER PAY ASSIGNMENT FORM

YOUR EMPLOYER MUST FILL OUT AND SIGN THIS FORM BEFORE YOU CAN BEGIN WORKING.

As the employer I am assigning the following pay rates to my employee. I understand that these rates only apply if my worker claims 40 hours or less per week. If my employee works over 40 hours per week I agree to contact All Saints Home Care to obtain a pay rate agreement.

Worker name_____ Rate $_____ Service_____

(day or sleep)

Worker name_____ Rate $_____ Service_____

(day or sleep)

Please choose a pay rate that coincides with the Medicaid Waiver you are on and services you receive.

FE Day	$7.25-$10.60
PD Day	$7.25-$11.00
TBI Day	$7.25-$11.60
Sleep Cycles	$7.25-$8.25

Client Signature_____

Client Name (please print)_____ Date _____