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 Direct Support Worker. I understand that these rates only apply if my worker claims 40 hours or less per week. If my Direct Support Workers works over 40 hours per week, I agree to contact All Saints Home Care to obtain a pay rate agreement.

Direct Support Worker name:_____ Rate: $_____Service: ☐ Day ☐ Sleep

Direct Support Worker name: _____ Rate: $_____Service: ☐ Day ☐ Sleep

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

PD Waiver		BI Waiver		FE Waiver	
PD Day	$7.25 – $11.85	BI Day	$7.25 - $11.85	FE Day	$7.25 - $13.00
PD Sleep	$7.25- $8.25	BI Sleep	$7.25 - $8.25	FE Sleep	$7.25 - $9.15

_____ _____

Client Signature Date

_____

Client Name (Please Print)

FOR OFFICE USE ONLY:

Authenticare #: _____ **CYMA #:** _____

Input: _____ **Date:** _____ **Audit:** _____ **Date:** _____

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