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: $_____Weekly Hours _____

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

PD Waiver		**BI Waiver**		**FE Waiver**	
PD Day	$7.25 – $13.10	BI Day	$7.25 - $13.10	FE Day	$7.25 - $14.40

_____ _____

Client Signature Date

_____

Client Name (Please Print)

FOR OFFICE USE ONLY:

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

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

3425 W Central
Wichita, KS 67203

Phone: 316-755-1076
Toll Free: 866-755-1076

Fax: 316-945-9076
Web: Allsaintshomecare.com