

Pay Rate Information- Nevada State Funded

Select the appropriate reason for this form: Initial Setup Change Existing Rate

REQUIRED INFORMATION	
Employer Name	ID
Caregiver Name	ID or Last 4 of SSN
Participant Name	ID

Below, please indicate the Pay Rate you are agreeing to and ensure it is within the allocated service authorization budget and program rules. A rate of pay should only be indicated for a service that is authorized in the plan of care and the worker is authorized to provide. If you have questions, speak with your Service Coordinator.

SERVICES COVERED	EFFECTIVE DATE*	HOURLY PAY RATE
BTM- Behavior Training/Management	____/____/____ MM/DD/YYYY	\$____.____ / hour
THR- Specialized Therapeutic Services	____/____/____ MM/DD/YYYY	\$____.____ / hour
REC- Social/Recreation	____/____/____ MM/DD/YYYY	\$____.____ / hour
LVS- Daily Living Skills	____/____/____ MM/DD/YYYY	\$____.____ / hour
SPC- Specialized Care	____/____/____ MM/DD/YYYY	\$____.____ / hour

*Rate of pay effective dates can never be in the past.

By signing below, the Employer and Worker certify that the information in this form is correct and was agreed to by both parties. For changes to existing rates, please allow five (5) days for processing. Once processed, the change will take effect the next pay period. Changes will not be applied retroactively to payments already made.

Worker Signature

Date

Employer Signature

Date

Please return this form to Palco via email: enrollment@palcofirst.com or via fax to 1.877.859.8757