Worker Pay Rate Information

Select the appropriate reason for this form:

☐ New Client Setup ☐ Change Existing Rate

REQUIRED INFORMATION	
Participant/Employer Name	ID
Worker Name	ID or Last 4 of SSN
Authorized Representative Name (if applicable)	ID (if applicable)

Below, please indicate the Pay Rate you are agreeing to. The Pay Rate is the amount that the Worker will receive per hour worked. **Please provide a Pay Rate for ONLY services approved in your Individual Plan of Service (IPOS).**

Rate Name	Hourly Rate
CLS Rate	
Respite Rate	
Overnight Rate	

By signing below, the Participant/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**

____ ______________________________

Participant/Employer Signature **Date**

Please return this form to Palco via fax: 1-877-859-8757, email: enrollment@palcofirst.com or mail: PO Box 242930, Little Rock, AR 72223