



## Employee Wage and Hours Agreement Form

Employer Name \_\_\_\_\_

Participant/Client Name \_\_\_\_\_

Employee Name \_\_\_\_\_

### **Service Codes and Wage Information**

Please indicate the employee's wage per hour for the following service codes:

1. Personal Care Services (PCS): \$ \_\_\_\_\_ per hour

2. Respite Care Services: \$ \_\_\_\_\_ per hour

### **Estimated Weekly Hours**

As the employer, provide an estimate of the number of hours per week the employee will work for each service:

1. Personal Care Services: \_\_\_\_\_ hours per week

2. Respite Care Services: \_\_\_\_\_ hours per week

Total estimated hours per week for both services combined: \_\_\_\_\_ hours per week

### **Work Hours Limitations and Conditions**

Please read and acknowledge the following conditions regarding work hours for employees:

- Employees who do not reside in the same household as the CAP Medicaid recipient (client) are limited to a combined total of 40 hours per week for both Personal Care Services and Respite Care Services.
- The 40-hour limit per week is inclusive of all services provided; employees may not work 40 hours in one service and 40 hours in another within the same week.
- Employees who live in the same household as the CAP Medicaid recipient (client) and are considered live-in employees may work over 40 hours per week. However, live-in employees are not eligible for overtime wages.

By signing below, both the employer and the employee acknowledge and agree to adhere to the work hours limitations and conditions as stated above.

Employer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Signature: \_\_\_\_\_ Date: \_\_\_\_\_