Participant Name	Employer Name	Employee Name

Qualified Worker Rate Change

The Participant or Representative fills out this form with each qualified Worker when they wish to pay the Worker for new service type or when they wish to change the Worker's current pay rate. ***Check the box of the service you are adding or modifying and indicate your desired rate.***

If this form is being used to change an existing pay rate, the rate change will go into effect on the next payroll after Public Partnerships receives the form. Changes will not be applied to dates already paid.

Worker Name: _____

Worker Signature: _____ Date: _____

Worker Social Security Number: _____

☐ New Service ☐ Change of Existing Rate

Service (Procedure Code)		Worker Rate per Hour
☐ Adult Companion Care	S5135	$
☐ Attendant Nursing Care	S5125	$
☐ Homemaker	S5130	$
☐ Personal Care Services	T1019	$
☐ Intermittent and Skilled Nursing (RN)	T1002	$
☐ Intermittent and Skilled Nursing (LPN)	T1003	$

Participant Name: _____

Representative's Name (if applicable): _____

Participant/Representative Signature: _____ Date: _____