CONSUMER DIRECT CARE NETWORK

Family Support 360 Waiver Program

WAGE MEMO

Employee Name	Participant Name	Designated Representative Name

Please select at least one service type below and enter the wages to be paid to the Employee.

Request Type and Effective Date:

☐ New Enrollment ☐ Updated Wage, if so: Effective Date: _____

Hourly Services – Service Name, Service Code, and Hourly Pay Rate
☐ S5125 – Personal Care $_____ per hour
☐ T1005 – Respite Care $_____ per hour
☐ T1020 – Companion Care $_____ per hour
☐ T2018 – Supported Employment Care $_____ per hour

By signing below, the Participant/Designated Representative and Employee agree to the pay rate(s) outlined above. The Participant/Designated Representative acknowledges that the rate is approved in their budget. This form must be received by CDCN two (2) weeks prior to the pay period start date for which the rate is to take effect.

_____ _____ _____ _____

Employee Signature *Date* *Participant/Designated Rep Signature* *Date*