HOME HELP AUDIT PAYROLL TEMPLATE

Michigan Department of Health and Human Services

This form is intended only for an audited Home Help agency provider (“agency”) that does not use a payroll company. Most payroll reports provided by payroll companies include all information needed to meet Home Help audit requirements. If your agency does not use a payroll company, you may use this form to meet the agency caregiver payroll record requirement. You may also choose to submit your agency’s own payroll documents if they include all the information in Section 2 of this form.

How to Complete This Form

This form is intended for one month of payroll records. A form must be completed for each month listed on the MDHHS audit or new agency provider compliance review letter.

SECTION 1: Enter all the required agency information. The information in this section must match the information in your agency’s Community Health Automated Medicaid Processing System (CHAMPS) enrollment.

SECTION 2: This form accommodates payroll records for five agency caregivers. If payroll records are required for more than five agency caregivers, multiple forms may be submitted. Enter all the following information:

A. **Payroll Period**: Enter the start and end dates of the one-month payroll period.
B. **Employee**: Enter the first and last names of all agency caregivers who provided Home Help services during the payroll period.
C. **Hours Worked**: For each caregiver, enter the total hours and minutes your agency paid the caregiver during the payroll period. If the agency caregiver provided services other than Home Help during the month, do not include the time the caregiver spent on those services. Enter the time in a hh.mm format. For example, 40 hours and 15 minutes would be entered as 40.25. For help entering minutes in a decimal format, see the “Conversion Table – Decimal Hours to Minutes” in Numbered Letter L 17-45.
D. **Pay Rate**: In the “Regular” field, enter the caregiver’s base pay rate. In the “Mandated Caregiver Wage Increase Passthrough” field, enter the MDHHS-mandated passthrough.
E. **Gross Amount**: In the “Regular” field, enter the total dollar amount calculated by multiplying the Hours Worked by the pay rate in the “Regular” Pay Rate field. In the “Mandated Caregiver Wage Increase Passthrough”, enter the total dollar amount calculated by multiplying the Hours Worked by the pay rate in the “Mandated Caregiver Wage Increase Passthrough” Pay Rate field. Add the two dollar amounts together and place the total dollar amount in the Total field.
F. **Overtime Pay Included**: Check this box only if the dollar amount in the Total field includes overtime pay.

SECTION 3: This section must only be signed and dated by an agency owner or managing employee. The signature must be handwritten. The signer must check the “Agency Owner” or “Managing Employee” box.

HOME HELP AGENCY PROVIDER AUDIT PAYROLL TEMPLATE

Michigan Department of Health and Human Services

SECTION 1 - Agency Provider Information

Agency Provider Name	CHAMPS Provider ID Number		
Employer Identification Number (EIN)	National Provider Identifier (NPI)		
Agency Provider Correspondence Street Address	City	State	Zip

SECTION 2 – Agency Caregiver Payroll Records

Payroll Period				
<Enter Payroll Period Start Date>		<Enter Payroll Period End Date>		
Employee	**Hours Worked**	**Pay Type**	**Pay Rate**	**Gross Amount**
<Enter Caregiver First and Last Name>	<hh.mm>	Regular	$	
		Mandated Caregiver Wage Increase Passthrough	$	$
		☐ Overtime Pay Included	**Total**	**$**
<Enter Caregiver First and Last Name>	<hh.mm>	Regular	$	$
		Mandated Caregiver Wage Increase Passthrough	$	$
		☐ Overtime Pay Included	**Total**	**$**
<Enter Caregiver First and Last Name>	<hh.mm>	Regular	$	$
		Mandated Caregiver Wage Increase Passthrough	$	$
		☐ Overtime Pay Included	**Total**	**$**
<Enter Caregiver First and Last Name>	<hh.mm>	Regular	$	$
		Mandated Caregiver Wage Increase Passthrough	$	$
		☐ Overtime Pay Included	**Total**	**$**
<Enter Caregiver First and Last Name>	<hh.mm>	Regular	$	$
		Mandated Caregiver Wage Increase Passthrough	$	$
		☐ Overtime Pay Included	**Total**	**$**

SECTION 3 – Attestation

With my handwritten signature below, I certify that a) the information provided on this form is correct and b) all caregivers providing Home Help services are associated to the agency in CHAMPS.		
Signature of Agency Owner or Managing Employee	Title of the Signer	Date Signed
	☐ Agency owner ☐ Managing employee	

Michigan Department of Health and Human Services (MDHHS)

Please note if needed, free language assistance services are available.

Call 800-642-3195 (TTY 866-501-5656).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-642-3195 (TTY 866-501-5656).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-642-3195 (رقم هاتف الصم والبكم: 866-501-5656).
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-642-3195 （TTY 866-501-5656）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܩܒܠܝܬܘܢ ܡܫܡܫܢܘܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 800-642-3195 (TTY 866-501-5656)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-642-3195 (TTY 866-501-5656).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-642-3195 (TTY 866-501-5656).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-642-3195 (TTY 866-501-5656)번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১ 800-642-3195 (TTY ১ 866-501-5656).
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-642-3195 (TTY 866-501-5656).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-642-3195 (TTY 866-501-5656).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-642-3195 (TTY 866-501-5656).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-642-3195（TTY 866-501-5656）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-642-3195 (телетайп 866-501-5656).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-642-3195 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 866-501-5656).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-642-3195 (TTY 866-501-5656).

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Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided the above services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, Suite 411
PO Box 30037
Lansing, MI 48909

517-284-1018 (Main), (TTY number—if covered entity has one), 517-335-6146 (Fax), MDHHS-Section-1557@michigan.gov (Email).

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.