

## WAGES AND BENEFITS PLAN

**Wages/Benefits:** Attendant will receive \$\_\_\_\_\_.\_\_\_\_\_ per hour.

**Benefits available to the Attendant:**

Sick leave; specify length of time, duration, when employee is eligible for the time, etc.:

Vacation time, specify length of time, when employee is eligible for the time, other conditions:

Over-time Rate: (a) Regular Hourly Rate \$\_\_\_\_.\_\_\_\_

(b) 1/2 of Regular Rate + \$\_\_\_\_.\_\_\_\_

(c) Over-time Rate = \$\_\_\_\_.\_\_\_\_ / per hour.

Holiday, specify holidays/dates, number of days or hours:\_\_\_\_\_

Bonus, specify amount and time period:\_\_\_\_\_

Work-related expenses, specify limit amount and specific expenses:\_\_\_\_\_

Workman's compensation or liability insurance (specify):\_\_\_\_\_

Other (specify):  
\_\_\_\_\_  
\_\_\_\_\_

**Time Sheets** must be completed accurately. Time sheets are due: \_\_\_\_\_

**Paychecks** will be distributed (method): \_\_\_\_\_; (frequency):  
\_\_\_\_ twice a month on \_\_\_\_\_ (OR) \_\_\_\_ every other week starting \_\_\_\_\_

**Note: Complete this box if you will not provide workman's compensation insurance to your Attendant.** Review the statement below with your Attendant and ask the Attendant to sign and date the statement.

I, (Print) \_\_\_\_\_ understand that in the event I am injured while assisting \_\_\_\_\_, I will be responsible for any medical treatments required. I further understand that I will not receive compensation for wages lost during recovery from my injury unless provided as a benefit and noted above.

(Signature) \_\_\_\_\_ (Date) \_\_\_\_\_

**THE VENDOR FISCAL INTERMEDIARY (VFI) AGENCY AND THE TEXAS DEPARTMENT OF HUMAN SERVICES (DHS) ARE NOT LIABLE FOR ANY INJURIES, OMISSIONS OR OTHER ACTS OF EITHER THE EMPLOYEE(S), THE EMPLOYER OR (IF APPLICABLE) THE DESIGNATED RESPONSIBLE PARTY.**

**Agreement:**

Employee and Employer mutually agree to the wages, benefits and information above and that any changes or revisions must be documented and signed by both parties.

Employee's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Employer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_