Personal Assistance Services Reimbursement for Employment Program
PASREP - Reimbursement Request

Participant:
Address:
Month: **Year:**

PA/Employee/Provider	Date Pd	Hours Pd	Hrly Rate	Gross Pay

This Month's PAS Total Hours and Gross Pay

Employer's Social Security (Gross pay x .062)
Employer's Medicare (Gross pay x .0145)
State Unemplmt (See Form UA 1771 for rate)
Federal Unemployment Tax (Gross pay x .008)
Worker's Compensation Insurance Cost
Total Employer Taxes/Insurance This Month

ADD Gross Pay and Employer Taxes

Amount Paid/Reimbursed by DHHS or other sources
Amt for which Participant is responsible, per approval letter
Total to be subtracted from Gross Pay and Taxes

Gross Pay and Taxes less subtractions, if any

Reimbursable amount equals line above or maximum indicated on approval letter
My signature below certifies the information on this form is correct.
I agree that a faxed copy of this signed form is as valid as my original signature.
Participant's Signature:_____ Date: _____
This form must be completed at the end of the month and received at the regional CIL by the 6th of the new month. It must then be forwarded to the lead CIL (DMM) by 10th of the month.
Regional CILs: **Rev 06/03/15**

Disability Network Mid-Michigan – 1705 S Saginaw Rd, Midland, MI 48640 - Fax: (989) 835-8121
Disability Network Wayne - 5555 Conner, Ste 2224, Detroit MI, 48213 - Fax: (313) 923-1404
Disability Advocates Kent Co. - 3600 Camelot Dr, SE, Grand Rapids, MI 49546 - Fax: (616) 949-1100
Disability Network Oakland/Macomb- 16645 15 Mile Rd, Clinton Twnp, MI 48038- Fax: (586) 285-9942