SAMPLE

(LOGO/COMPANY NAME)

DIRECT CARE WORKER PREMIUM PAY ATTESTATION FORM

To ensure your wages have been increased appropriately based on the MDHHS prescribed COVID-19 Premium Pay Direct Care Worker Temporary Wage Increase for qualifying services performed for your employer, please attest below:

I, _____(Employee Name), confirm

that my wages have been increased by _____(Amount) per hour by my

Employer, _____

(Employer Name) for the period _____ (Start Date) through and

including _____ (End Date).

_____ _____

Employee Signature **Date**

_____ _____

Employer Signature **Date**