PHB PAYROLL AMENDMENT FORM

Recipients Name: ……………………………………………….……………………….

Representative/Employers Name: ………………………………………….. (if applicable)

Please complete this form for any changes to your employee/s contracted hours. Contracted hours of work are the basic minimum hours your employee works **each week.**

**IT IS YOUR RESPONSIBILITY TO CONTACT US WITH ANY CHANGES TO THE CONTRACTED HOURS.**

|  |  |  |
| --- | --- | --- |
| **Name of Personal Assistant** | **Weekly Contracted hours of work**  | **Overnight Night Rate (10pm – 8am)** |
| **Print Name** |  | **hrs** | **Nights** |
| **Start date** |  | **£ per hour** | **£ per night** |

|  |  |  |
| --- | --- | --- |
| **Name of Personal Assistant** | **Weekly Contracted hours of work**  | **Overnight Night Rate (10pm – 8am)** |
| **Print Name** |  | **hrs** | **Nights** |
| **Start date** |  | **£ per hour** | **£ per night** |

|  |  |  |
| --- | --- | --- |
| **Name of Personal Assistant** | **Weekly Contracted hours of work**  | **Overnight Night Rate (10pm – 8am)** |
| **Print Name** |  | **hrs** | **Nights** |
| **Start date** |  | **£ per hour** | **£ per night** |

*I understand that if I do not inform the Personal Health Budgets Team of any variance in my employee’s hours; including any Bank Holidays they may work; my employee will be paid for the hours stated on this sheet.*

**Please read and sign the declaration on the back of this form.**

**By signing this declaration, you are agreeing that you have read and understood the following responsibilities:**

1. You are responsible for managing the budget to ensure that you have enough funds to meet your statutory employer costs, for example:

*Holiday Pay, Statutory Sick Pay, Statutory Maternity/Paternity Pay, pensions etc.*

1. Payroll can only produce Payslips based on your individual assessed hours.
2. It is a Criminal offence for Employers not to pay the National Minimum Wage and failure to comply can result in being fined.
3. You must provide the Direct Payments Team with an up to date copy of your Public/Employers liability insurance certificate.

Employers Name: ………………………………………………………

Employers Signature: ………………………………………………….

Date: ………………………………………..

|  |  |  |  |
| --- | --- | --- | --- |
| For Office Use only  Week/Date effective from | **Authorised by** | **Amended by** | **Date** |
|  |  |  |  |