CARERS TRUST
Sefton Carers Centre

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**

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I understand that if I do not inform the Direct Payments 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.

2. If you decide to pay your workers over and above the **maximum amount that Sefton advise**, you are responsible for this additional cost from your own personal funds should a shortfall occur in your account.

3. Payroll can only produce Payslips based on your individual assessed hours. The Direct Payments Team cannot authorise the use of additional hours unless confirmation is received from the Social Work Team.

4. It is a Criminal offence for Employers not to pay the National Minimum Wage and failure to comply can result in being fined.

5. 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**