## NC Office of State Human Resources

**2018 - 2019 Salary Plan Reporting Form**

**(for County DSS and Public Health)**

Name of County/Local Jurisdiction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Individual Completing Form \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

E-Mail Address of Pay Plan Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective Date of Pay Plan 1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Increase in Schedule 2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount of Increase given to Employees 3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Agencies covered by this salary plan: Social Services \_\_\_\_ Total # DSS Positions \_\_\_\_

 Public Health \_\_\_\_ Total # PH Positions \_\_\_\_

 Mental Health \_\_\_\_ Total # MH Positions \_\_\_\_

5. With the exception of employees in trainee status, the

 salaries of all SPA employees must be between the minimum

 and the maximum of the assigned range.

 Does your jurisdiction meet this requirement? ( ) Yes ( ) No

 If “No”, please explain.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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6. Are the salaries of all employees in trainee status

 below the minimum rate for the full class? ( ) Yes ( ) No

7. Has your Area, District Board, or Board of

 Commissioners approved the plan? ( ) Yes ( ) No

8. Do all pay rates reflected on your salary schedule

 meet the State minimum wage of $7.25? ( ) Yes ( ) No

9. Have you attached a copy of your approved salary schedule? ( ) Yes ( ) No

 **You must answer “Yes” to questions 6, 7, 8 and 9, before submitting your form.**

**2018 - 2019 LOCAL SALARY PLAN**

Please enter the salary grade you have assigned your jurisdiction’s SPA classes in the block labeled “County Grade.” Only those classes in use, or which you anticipate needing this fiscal year should be included.

Please verify that the required pay grade relationships have been maintained within Occupational Groupings. This can be done by subtracting the number in the State SG column from the number in the County SG column. If you have entered your salary schedule information in the Local Government Salary Plan spreadsheet these numbers will populate automatically. **The numbers in the “Rel Dif” column must be identical for each class you are reporting within the same occupational grouping.** The separate occupational groups are differentiated by bold lines to assist you in identifying classes having required relationships.

The following sections should be completed, listing salary grades (or minimum salary rates) assigned to your **County Social Services, Local Health and Area Mental Health Directors**, and **Human Services Deputy Director** positions:

### Social Services Jurisdictions

10. Title of the highest level class supervised by County Social Services Director**, excluding Human Services Deputy Director and the Attorney series**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

11. Grade of highest level supervised \_\_\_ 12. Minimum Rate \_\_\_\_\_\_\_

13. Grade of County Social Services Director (if app) \_\_\_ 14. Minimum Rate \_\_\_\_\_\_\_

15. Subtract line 12 from line 14. \_\_\_\_\_\_\_\_\_\_\_ 16. Divide by line 12. \_\_\_\_%

17. Is the resulting answer between 20% and 60% ( ) Yes ( ) No

 **You must answer “Yes” to question 17 before submitting your form.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### Single and Multi-County District Health Jurisdictions

18. Title of the highest level class supervised by Local Health Director, **excluding**

**Physicians, Physician Extenders, Pharmacists, Dentists and Human Services Deputy Director**:

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

19. Grade of highest level supervised \_\_\_\_\_ 20. Minimum Rate \_\_\_\_\_\_\_

21. Grade of Local Health Director (if app) \_\_\_\_\_ 22. Minimum Rate \_\_\_\_\_\_\_

23. Subtract line 20 from line 22. \_\_\_\_\_\_\_\_\_\_\_ 24. Divide by line 20. \_\_\_\_%

25. Is the resulting answer between 20% and 60% ( ) Yes ( ) No

 **You must answer “Yes” to question 25 before submitting your form.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Social Services, Public Health and Area Mental Health Jurisdictions:**

34. Title of the Director class under which **Human Services Deputy Director** serves: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

35. Grade of highest level supervised by Director \_\_\_ 36. Minimum Rate \_\_\_\_\_\_\_

37. Grade of HSDD \_\_\_ 38. Minimum Rate \_\_\_\_\_\_\_

39. Subtract line 36 from line 38. \_\_\_\_\_\_\_\_\_\_\_ 40. Divide by line 36. \_\_\_\_%

41. Is the resulting answer between 10% and 40% ( ) Yes ( ) No

 **You must answer “Yes” to question 41 before submitting your form.**

**CERTIFICATION OF SALARY PLAN**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Single Reporting Jurisdictions**

I hereby certify that the attached salary plan submitted for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County, is complete and compliant with all the relevant provisions in NCGS 126, the State Human Resources Act. Furthermore, the salary plan was completed in accordance with the instructions that have been provided and is deemed accurate at the time of submission. I further certify that I am the authorized official.

(Electronic signatures are acceptable.)

Signature of Authorized Official \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### District Health Jurisdictions

42. Does your pay plan exceed the highest paying member

 county in your Area? ( ) Yes ( ) No

43. If “yes”, have you received authorization from all counties

 in the area to exceed? ( ) Yes ( ) No

 **You must answer “Yes” to question 43 before submitting your form. \_\_\_\_\_\_\_\_\_\_**

If you answered “No” to question 42, please complete as follows: I hereby certify that the attached salary plan submitted for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District Health, is complete and compliant with all the relevant provisions in NCGS 126, the State Human Resources Act. Furthermore, the salary plan was completed in accordance with the instructions that have been provided and is deemed accurate at the time of submission. (Electronic signatures are acceptable.)

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you answered “Yes” to questions 42 and 43, please complete as follows: We, the Area Mental Health or District Health Board Chairperson, and the Chairperson of the Board of County Commissioners of each member county; or the County Commissioner Representative on the Area Mental Health or District Health Board (acting on behalf of their respective Boards of County Commissioners in authorizing that the Area or District Health pay plan may exceed that of the highest paying county); hereby certify that the attached salary plan submitted for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Area Mental Health or District Health is complete and compliant with all the relevant provisions in NCGS 126, the State Human Resources Act. Furthermore, the salary plan was completed in accordance with the instructions that have been provided and is deemed accurate at the time of submission. (Electronic signatures are acceptable.)

Jurisdiction \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_Board Chairperson**\_\_\_**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you need assistance, please contact your assigned HR Consultant (see LG Contacts Listing on OSHR website).

**PLEASE E-MAIL THIS COMPLETED REPORTING FORM WITH THE ELECTRONIC SIGNATURES BY JULY 20, 2018 TO:**

e-mail: **localsalary.plans@nc.gov**