Agency Name: Provider ID: Agency Representative Name and Title: Agency Representative Contact Information (address, phone # and email): Waiver Program: TBI (Note: only include TBI staff on this spreadsheet, do not duplicate staff across waiver programs) **RRDC Region: Date of Request:** Total Stipend Amount Requested With This Submission (do not enter anything, this is auto-summed): \$0.00 **Employee Information Participant Information** (Staff must have been employed during the PHE period beginning April 1, 2021. Training must be dated during the (List the associated information for 1 person Appendix K period, starting 4/1/2021. Provider must have completed training certificate(s) available upon request.) on employee's caseload) **Total Stipend Employee Name** Stipend Date of Stipend Stipend **Participant Name** Waiver Date of Date of CIN Amount Sought Completed Amount Intial Waiver Amount Most **Program** Requested for for PCA/ Sought for Recent (Must be Employee PCA/ Alternate Sought for Staff TBI) Competency **Initial Waiver** Training Annual (Auto-sum, do not **Alternate** Annual Competency Training Staff Training (If Training Training enter any values here) Training (If applicable) (Enter \$100 if applicable) (Enter \$100 seeking (Max of \$350 for each applicable) reimbursement) stipend) annual training) **EXAMPLE LINE: Jane Doe** \$350.00 4/20/2021 \$100.00 4/21/2021 \$100.00 4/21/2022 John Doe AA12345B TBI \$550.00

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•	Employee Information (Staff must have been employed during the PHE period beginning April 1, 2021. Training must be dated during the Appendix K period, starting 4/1/2021. Provider must have completed training certificate(s) available upon request.)									
Employee Name	Amount Sought	Date of Completed PCA/ Alternate		Intial Waiver	Stipend Amount Sought for	Date of Most Recent	Participant Name		Program	Total Stipend Requested for Employee
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