Agency Name:											
Provider ID:											
Agency Representative I	Name and Ti	tle:									
Agency Representative (			ess, phone #	and email):							
Waiver Program: TBI											
(Note: only include TBI sta	iff on this spre	eadsheet, do no	ot duplicate st	taff across wai	iver programs)						
RRDC Region:											
Date of Request:	oguested Wit	th Thic Cubmi	ssion (do no	t optor opythin	a this is outs summ	aad):	T	\$0.00	<b>\</b>		
otal Stipend Amount Requested With This Submission (do not enter anything, this is auto-summed): \$0.00											
		Employee Info				_	ant Informati				
(Note: Employees listed mus	st nave provide	d at least 30 day 3/1/2020		uring the Apper	ndix K period, starting	•	ed information ployee's casel	•			
	I		<u></u>	Inc	la		•				
Employee Name	Date of Hire	Employment Employment	Waiver	If Meets	-	Participant Name	CIN	Waiver	Total Stipend		
		End Date (If currently	Service Provided	Vaccination Criteria,	Sought (Auto-sum, do not			Program (Must be	Requested for Employee		
		employed,	Fiovided	Enter \$500	enter any values here)			TBI)	(Auto-sum, do not		
		enter "N/A")		2.11.01 4000	(\$2,500 (hired on or			,	enter any values		
		,			after 4/1/21) or \$3,000				here)		
					(hired before 4/1/21))						
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EXAMPLE LINE: Jane Doe	4/1/2020	N/A	HCSS	\$500.00		John Doe	AA12345B	TBI	\$3,500		
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Employee Name	Date of Hire	Employment End Date (If currently employed, enter "N/A")	Waiver Service Provided	If Meets Vaccination Criteria, Enter \$500	Stipend Amount Sought (Auto-sum, do not enter any values here) (\$2,500 (hired on or after 4/1/21) or \$3,000 (hired before 4/1/21))		Waiver Program (Must be TBI)	Total Stipend Requested for Employee (Auto-sum, do not enter any values here)
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Employee Information (Note: Employees listed must have provided at least 30 days of service during the Appendix K period, starting 3/1/2020)						Participant Information (List the associated information for 1 person on the employee's caseload)			
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