TBI Workforce Stability Stipend Attachment

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 (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)			
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))	**Participant Name**	**CIN**	**Waiver Program** (Must be TBI)	**Total Stipend Requested for Employee** (Auto-sum, do not enter any values here)
EXAMPLE LINE: Jane Doe	4/1/2020	N/A	HCSS	$500.00	$3,000	John Doe	AA12345B	TBI	$3,500
					$0.00				$0
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