TBI Training 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 (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.)							**Participant Information** (List the associated information for 1 person on employee's caseload)			
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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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