

Medina County Board of Developmental Disabilities

HPC DSP Retention Support

(Providers may apply for approved funds based on a first-come, first-served basis while funds are available at the discretion of the MCBDD)

Provider Name:

Date of Request:

Contact Person:

Contact Phone:

Contact Email:

Address for reimbursement checks:

RETENTION BONUS: DSP Name(s) (Attach additional page if necessary)	Avg. Hours worked per week	Month achieved 100%	Amount paid to DSP	Date of payment to DSP
			\$ -	
			\$ -	
Reimbursement Request Total:			\$ -	

By signing below, I hereby attest that the information stated above is true and accurate to the best of my knowledge. Funds requested will be used only for DSP's providing ongoing services to individuals supported by MCBDD. MCBDD will request repayment of funds if it is determined that funds were distributed and not used as intended or reimbursed by another funding source.

Applicant Signature

Applicant Title

Date

**Send completed form along with corresponding documentation to Pam Hunt:

pamh@mcbdd.org by the 25th of the following month

Any questions, please contact Pam Hunt 330-725-7751 ext. 261

No reimbursement requests will be accepted after 1/31/2023.