ATTACHMENT XIII

Personnel Form

Provider/Grantee Name:

Service Period:

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name of Employee on CTG Grant** | **Hourly Rate** | **% of Time on CTG**  **Project** | **Salary** | **Retire- ment Amount** | **FICA**  **Amount** | **Workers Comp. Amount** | **Medical Ins.** | **Life Ins.** | **Cash Match Amount** | **Total Salary & Benefits paid by CTG** | **Total Invoiced to OMH - CTG** |
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| **Total** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| **CERTIFICATION STATEMENT:** The information reported on this form is true and correct. The source of non-state funds used for MATCH amounts reported for salaries and benefits are correct and have not been used in any other state assisted project or program. If MATCH is not required, insert N/A in the indicated column.  Signature: Date: | | | | | | | | | | | |

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