ODP ARPA CPS Supplemental Payment Application For Providers

Provider Name: MPI:

Contact Name: Email:

CPS Providers:

Total number of unique individuals who received waiver funded (Consolidated, P/FDS and Community Living) CPS from your agency during fiscal year 19/20

Total number of unique individuals who received waiver funded (Consolidated, P/FDS and Community Living) CPS from your agency during fiscal year 22/23

Employment Service Provider:

Total number of unique individuals who received waiver funded (Consolidated, P/FDS and Community Living) Employment Services from your agency during fiscal year 19/20

Total number of unique individuals who received waiver funded (Consolidated, P/FDS and Community Living) Employment Services from your agency during fiscal year 22/23

Supports Coordination Organizations:

Total number of unique individuals who received ODP funded (Base, TSM, Consolidated, P/FDS and Community Living) Supports Coordination from your agency during the first six months of fiscal year 22/23 (July 1, 2022 to December 31, 2022)

Total number of unique individuals who received ODP funded (Base, TSM, Consolidated, P/FDS and Community Living) Supports Coordination from your agency during the second six months of fiscal year 22/23 (January 1, 2023 to June 30, 2023)

If eligible, I am confirming that my agency wishes to receive these supplemental payments. I understand that ODP will review billing history to confirm the numbers entered above and if discrepancies exist, I will be expected to provide unique MCI's for the individuals served.

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Signature of legal representative

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Printed name of legal representative