# WOOD COUNTY
## BOARD OF DEVELOPMENTAL DISABILITIES

Request for Training Initiative Reimbursement

*Complete request for each course date separately.

Independent/Agency Name:_____

Phone Number:_____ Email:_____

Applying for: ☐ Provider Annual Training (PAT): Course Start Date _____

☐ Positive Supports First (PSF): Course Start Date _____

☐ Medication Administration (MEDCERT): Course Start Date _____

☐ Career Communities (COMM): Course Start Date _____

☑ Competency Based Longevity Add On (CAOT): Course Start Date _____

| Direct Support Professional Name (Agencies Only) | Site and/or Individuals Served (Required for ALL) |
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This form must be completed when requesting DSPs training initiative reimbursement.

Submit this form along with W-9 annually to: ablake@woodcountydd.org

**Additional information may be requested to verify the DSP is working in Wood County**

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Provider Relations Department Use Only

Application Received on:_____ Initials:_____

☐ Approved ☐ Denied and Reason of Denial:_____

Verification Certificate received: No☐ Yes☐

Total Hours Documented: _____

_____ _____

Provider Relations Dept Signature Date