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
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: _____