



ATTACHMENT: PARTICIPATING STAFF

To be completed by an official at the agency requesting participation in the PACTS RFA and signed by the Executive Sponsor or Chief Executive Officer.

Provider Name: _____

Level of Care: _____

Program Name (if applicable): _____

Name	Role (Clinician, Supervisor, Leadership, PE Point Person)	Credential/Licensed	Salaried or Contract

Completed by (Name/Title): _____

Signature: _____ Date: _____

Exec. Director Signature: _____ Date: _____