

## HEALTHCARE STIPEND REQUEST

Comments:			Today's Date:		
Participant Full Name:  First MI Last  Amount of stipend to be paid: \$  Comments:					
Participant Full Name:First MI Last  Amount of stipend to be paid: \$  Comments:	Direct Care Worker Full Name:	<del>-</del>			
Amount of stipend to be paid: \$  Comments:		First	MI	Last	
Amount of stipend to be paid: \$  Comments:  Worksite Employer: Please submit this to sequoiahr@SequioaSD.com to process.	Participant Full Name:	Eirct	MI	Lact	
Comments:		FIISt	IVII	Lasi	
	Amount of stipend to be paid: \$				
Worksite Employer: Please submit this to sequelabr@SequiesSD.com to process	Comments:				
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worksite Employer. Flease submit this to <u>sequoiding-sequiodsD.com</u> to process.	Worksite Employer: Please submi	t this to <u>sequoiahr@Se</u>	equioaSD.com to proc	ess.	
Participant/Representative Signature: Date:	Particinant/Ponrocontativo Signatu	Iro.		Date:	