

**UNITED STATES VIRGIN ISLANDS  
ELIGIBLE PROVIDER CERTIFICATION SYSTEM**

*Application for Initial Eligibility  
Under the Workforce Innovation and Opportunity Act*

**TRAINING PROVIDER INFORMATION**

Institution/Agency Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Contact Person/Title: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Facsimile Number: \_\_\_\_\_

E-mail: \_\_\_\_\_

Website: \_\_\_\_\_

Virgin Islands Tax Identification Number: \_\_\_\_\_

**PROGRAM DESCRIPTION**

1. Program Name \_\_\_\_\_

2. Training Location \_\_\_\_\_

3. Is this location compliant with the Americans with Disabilities Act?  
\_\_\_\_ Yes \_\_\_\_ No

4. Program Synopsis (50 words limit)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Program Contact Hours \_\_\_\_\_

6. Prerequisites (include testing requirements, if any)

\_\_\_\_\_  
\_\_\_\_\_

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7. How does your program accommodate customers with various disabilities? \_\_\_\_\_

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*\*All applicants seeking eligibility for financial assistance under Title I of the Workforce Innovation and Opportunity Act **must** make assurances that they are able to provide programmatic and architectural accessibility to individuals with disabilities.*

8. Program Category (*check one*)

- Adult Education/Literacy *only* in combination with Occupational Skills training
- Entrepreneurial Training
- Occupational Skills
- Skill Upgrading/Retraining
- Job Readiness *in combination with* Occupational/Entrepreneurial Training
- Workplace training with Related Instruction – to include cooperative education
- Other (specify): \_\_\_\_\_

9. Describe briefly the skill(s) that will be acquired through the program of training services.

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10. Demand Sector (*check one*)

- Administrative or Support Services
- Allied Health
- Construction Trades
- Information Technology
- Leisure and Hospitality
- Retail
- Transportation and Logistics

*(Please see Demand Occupation List for occupations in demand within each sector)*

11. Please describe the type of credential (and authorizing body issuing the credential) that will be obtained at the completion of training. (*All credentials must be nationally/industry recognized*)

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12. Is this program a “demand occupation” in the Territory based on the list of demand occupations provided you? \_\_\_\_\_ Yes \_\_\_\_\_ No

If not, please describe the benefit(s) of this type of training activity.

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13. What is the class size? \_\_\_\_\_

14. What is the instructor to student ratio? \_\_\_\_\_

15. How will participant progress be measured? (Include testing, evaluation, demonstration or other)?

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16. Please describe your organization’s placement policy. *\*(All providers are required to track participant’s placement and retention in employment for 12 months after credentials are acquired)*

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WIOA Performance Measures

All programs except Registered Apprenticeships are required by WIOA to provide verifiable program specific performance information on all class/cohort participants – even those not funded by WIOA. The measures are:

- Percent Employed at 2<sup>nd</sup> quarter after program exit.
- Percent Employed at 4<sup>th</sup> quarter after program exit.
- Median Earnings at 2<sup>nd</sup> quarter after program exit.
- Credential attainment (up to one (1) year after program exit).
- Measurable Skill Gains.

Providers are asked to collect and track this information during and after any training program where one or more participants are funded by WIOA. Providers are required to report on this information annually.

Any training provider who does not collect, track and report on these measures will NOT be eligible for “continued eligibility” under the Workforce Innovation and Opportunity Act (WIOA)

**DEMONSTRATED PERFORMANCE**

*Indicate previous experience and/or performance with employment and training activities, public and/or private, for the past two (2) years.*

1. Have you previously provided training services in the Territory?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
  
2. Provide the name and description of program including actual dates of operation.  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Funding Source(s) or Sponsoring Agency(ies)  
\_\_\_\_\_
  
4. Name and Mailing Address of Contact Person \_\_\_\_\_  
\_\_\_\_\_
  
5. Amount of Funds Received \$ \_\_\_\_\_
  
6. Program Completion Rate \_\_\_\_\_%
  
7. Participant Entered Employment Rate \_\_\_\_\_%
  
8. If you have not had past experience in providing training services, describe/explain what qualifies you to receive funds for this purpose: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**COST INFORMATION**

1. Cost of Program (Tuition Per Person): \$\_\_\_\_\_
2. Please list all costs covered by tuition (per person)

| <b>COST</b> | <b>DESCRIPTION OF ITEM</b> |
|-------------|----------------------------|
|             |                            |
|             |                            |
|             |                            |
|             |                            |
|             |                            |
|             |                            |
|             |                            |

3. Please list additional costs (per person) not covered by tuition, if applicable

| <b>COST</b> | <b>DESCRIPTION OF ITEM</b> |
|-------------|----------------------------|
|             |                            |
|             |                            |
|             |                            |
|             |                            |
|             |                            |

4. Please note that payments to providers for WIOA customers are based on their attendance and performance throughout the program. WIOA payments are made at midpoint and ending of the program, based on data submitted by the provider and verified by the monitoring unit.

Each service provider’s payment policy should be posted on their respective application for the benefit of those individuals interested in taking classes but, who are NOT funded through WIOA.

**ADDITIONAL INFORMATION**

1. Please provide documents that indicate your organization's ability to train in the specific field(s) described in this application.
2. Please provide a copy of the organization's current Virgin Islands' Business License, if applicable.
3. Letter of Good Standing from the Lieutenant Governor's Office dated within past twelve (12) months.
4. If you are incorporated, please attach a copy of your incorporation papers and Certification of Good Standing from the Lieutenant Governor's Office.

For each training program you are proposing to be offered to Workforce Innovation and Opportunity Act customers, please also enclose:

1. A schedule for the training program. Indicate beginning and ending dates for course(s), hours for classes, holidays and vacation periods.
2. The course curriculum. Include current resumes of the instructors.
3. Proof of affiliation with organization/institution issuing recognized training credential.
4. A Statement of Work describing program goals deliverables and anticipated outcomes.

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Attachments: Background Information  
Demand Occupation List

**CERTIFICATION OF COMPLIANCE WITH THE SPECIFICATIONS**

This is to certify that to the best of the undersigned knowledge and belief the data in this application is responsive to the specifications and is true and correct. The undersigned understands that non-responsive applications, as determined by the VIDOL/WIB, may not be reviewed for consideration. Further, the submission of this application has been authorized by the governing body of applicant, and applicant shall comply with both the assurance as applicable and regulations attached to the application package.

**Signature** \_\_\_\_\_

**Typed Name** \_\_\_\_\_

**Title** \_\_\_\_\_

**Date** \_\_\_\_\_

*Note: An executed certification must be returned with each proposal.*