

**UNITED STATES VIRGIN ISLANDS
PROVIDER CERTIFICATION SYSTEM**

*Proposal for Incumbent Worker Training
Under the Workforce Innovation and Opportunity Act*

A. EMPLOYER INFORMATION

Company's Name: _____

Mailing Address: _____

Contact Person/Title: _____

Telephone Number: _____

Facsimile Number: _____

E-mail Address: _____

Virgin Islands Tax Identification Number: _____

Please list current job titles, job titles for which training is being given (if changed), and salaries of employees after training:

#	Current Job Title	Job Title After Training	Salary

1. Total Number of People to be trained _____

2. Purpose of Training (50 words limit)



B. TRAINING PROVIDER INFORMATION

Institution/Agency Name: _____

Mailing Address: _____

Contact Person/Title: _____

Telephone Number: _____

Facsimile Number: _____

E-mail: _____

Website: _____

Check One: For Profit _____ Not for Profit _____

Virgin Islands Tax Identification Number: _____

C. PROGRAM DESCRIPTION

3. Program Name _____

4. Training Location _____

5. Is this location compliant with the Americans with Disabilities Act?
_____ Yes _____ No

All applicants seeking eligibility for financial assistance under Title I of the Workforce Innovation and Opportunity Act of 2014 **must make assurances that they are able to provide programmatic and architectural accessibility to individuals with disabilities.*

6. How does your program accommodate customers with various disabilities?

7. Total Cost of Program \$ _____

8. Program Contact Hours _____

9. Start Date _____ End Date _____



10. Weekly Schedule:

Days	Start and End Times
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

11. Describe briefly the outcome expected at the completion of training.

12. Please describe the type of certification that will be obtained at the completion of training.

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

14. Please provide a brief statement of the impact to your organization if this training does **not** occur.

D. BUDGET INFORMATION

Grant Cost Analysis

The proposing organization must submit a complete budget. The budget must be in line item format according to whether costs are administrative or training.

Note: Round all numbers to the nearest dollar

1. ADMINISTRATIVE COSTS

- 1. Staff Salaries _____
- 2. Staff Fringe Benefits _____
- 3. Communications _____
- 4. Utilities _____
- 5. Materials and Supplies _____
- 6. Insurance _____
- 7. Contractual Services _____
- 8. Lease and Rentals _____
- 9. Equipment _____
- 10. Other _____

Total Administrative Costs \$ _____

List any in-kind contributions.

2. DIRECT TRAINING COSTS

Line Item 2.a Staff Costs – Training

(Include only those staff persons that provide direct instructions or instruction-related services to trainees. Examples include training director, instructors, and clerical services to the training staff.)

Number	Position/Title	Salary per week or hour	% of Time to Project	Number. of weeks or hours	Total Salary

Total Staff Salaries – Training \$ _____
Enter on line item 2.a.

Line Item 2.b Staff Fringe Benefits – Training

(Employers cost of fringe benefits for Staff)

F.I.C.A. _____ % x _____ = \$ _____

Workmen’s Compensation _____ % x \$ _____ = \$ _____

Health & Welfare Insurance _____ % x \$ _____ = \$ _____

 Retirement _____ % x \$ _____ = \$ _____

 Pension _____ % x \$ _____ = \$ _____

Other (Specify) _____ = \$ _____

Total Fringe \$ _____
Enter on line item 2.b

(Employer’s cost of fringe benefits for staff - enter only costs being claimed for reimbursement)

Line Item 2.c. Equipment - Training

List below all equipment, materials and supplies necessary to the operation of the program that are to be charged to training. Indicate by letter in the “unit price” column whether the price is for purchase (p), rental (r) or leasing (l).*

Type	Quantity	Unit Price	Total

Total Equipment Costs \$ _____

Enter on line item 2.c

** A separate inventory must be maintained for all equipment leased/purchased through grant funds. All equipment, at the discretion of the grant recipient, must be returned to designated location no later than thirty (30) days after grant termination. No lease may extend past grant termination. In all cases, the leasing or rental of equipment, rather than purchase is encouraged.*

Line Item 2.d Other Training Costs (Supportive Services)

Specify Each Cost

ITEM	COST

Total \$ _____

Enter on line item 2.d

TOTAL COSTS

TOTAL ADMINISTRATIVE COSTS \$ _____

Training Costs

Line Item 2.a – Salaries \$ _____

Line Item 2.b – Fringe Benefits \$ _____

Line Item 2.c – Equipment and Supplies \$ _____

Line Item 2.d– Other (Supportive Services) \$ _____

TOTAL TRAINING COSTS \$ _____

TOTAL PROGRAM BUDGET \$ _____
(Total Administrative + Total Training)

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/WDB, 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.