STRATEGIC WORKFORCE TRAINING PLAN TEMPLATE

(Final Work Product for Planning Phase I)

The following is the Strategic Workforce Training Plan template. This template will be completed and submitted as the final work product produced as a result of Phase I awards funded with this RFP. In addition, this plan/template will be used to request funds for an Implementation Phase II. Delaware does have the right to edit this template.

This should not be completed and submitted for Planning Phase I funds. See Appendix D for Phase I Proposal Submission Template and Required Template Attachments, unless otherwise noted

STRATEGIC WORKFORCE TRAINING PLAN TEMPLATE

(TRAIN Phase II Funding Request)

1. **General Proposal Information**
2. **Name and Address of Lead Applicant Organization**

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

 (NAME)

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

 (STREET)

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

 (CITY, STATE) (ZIP CODE)

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

 (CONTACT PERSON)

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

 (TELEPHONE NUMBER)

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

 (E-MAIL ADDRESS)

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

 (Website URL)

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

(LOCATION(S) OF PROGRAM OPERATION - CITY/TOWN, COUNTY (if different from address above)

 **County (ies) this program will serve?**

[ ]  New Castle County

[ ]  Kent County

[ ]  Sussex County

[ ]  Statewide

**DUNS #:**

 **EIN ID #:**

1. **Lead Organization Type**:

[ ]  Non Profit

[ ]  Governmental

[ ]  Private for Profit

1. **It has been determined that there is a need for a Strategic Workforce Training Plan**

[ ]  Yes (continue to question 4)

[ ]  No (Submit a final report as a narrative attached to this first page along with a final financial report).

1. **Proposed Contract Period** (Must be within September 1, 2019-August 31, 2020).

Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_

1. **Proposed Name of Training Program Partnership:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
2. **Targeted Industry:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**OR**

**Targeted Common Skill(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Funding**:

Total Amount Requested: $\_\_\_\_\_\_\_\_\_\_\_\_\_

Requested funds for this program are % of organization's total budget.

Leveraged Resources Provided if any:

* Cash Contribution Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* In-Kind Amount:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

These leveraged funds will support the following: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Amount of Training Expense to be paid by the Trainee: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of services/supplies to be paid by Trainee: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Projected number of trainees needed to fill the identified industry/skills needs within the next year**:\_\_\_\_\_\_\_\_
2. **Proposed Number of Participants this will serve (trainees):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. **Proposed Number of Cycles of Training**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete the following (add more rows as needed):

|  |  |  |
| --- | --- | --- |
| Cycle # | Start/End Date | Cost |
|  |  |  |
|  |  |  |

If awarded a contract, are you willing to offer fewer cycles than proposed? Y/N

 Minimum number of cycles you would be willing to implement:

1. **Proposed Total Training Hours per Participant**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Proposed Outcomes to be Achieved**

The following will be the minimum Performance Outcomes expected from Phase II programs, unless indicated below the Performance Outcome Chart

|  |  |
| --- | --- |
| Performance Outcome | Goal |
| Enrollment | 100% |
| Completion of Proposed Training | 85% |
| Obtained Employment or Upgrade (Day 1) | 75% |
| Retained Employment for 30 Days | 70% |
| Retained Employment for 90 Days | 70% |

**Proposed Performance Outcomes differ from above chart** [ ]  Yes [ ]  No.

**If yes, the Proposed Performance Outcomes are** (must include employment related outcomes)**:**

1. **Briefly describe the end state this proposal seeks to accomplish for both employers and trainees. Address how each will benefit.**
2. **PROPOSAL NARRATIVES-**No answer shall exceed one page.

**Identification and Assessment of the Target Industry/Skills**

1. Outline the critical occupation and skills needs the proposed training will address.
2. Describe the process to identify such occupation and skills needs and provide basic industry and labor market analysis that supports the rationale for selecting the proposed training.
3. Describe the process in how the Applicant Group has defined their actual and projected workforce needs. How will the partnership continue this process to ensure projections continue and needs are being met?

**Key People**

1. Complete the following chart detailing the partners involved:

|  |  |  |  |
| --- | --- | --- | --- |
| **Organization Type** (i.e. Employer, Education/Trainer, or Other Partner) | **Name of Organization** | **Organization Contact and Contact Information** (include phone number and email) | **Role/Commitment** |
|  |  |  |  |

1. Describe preliminary plans to solicit feedback as to the value and impact of the training and the partnership generally.
2. Describe plans to ensure the sustainability of the partnership in the absence of funding.

**Core Features**

### Intensity/Duration – Describe the intensity of the service to participants, including hours of participation. In addition identify the enrollment schedule, training schedule and the duration of the program including any post-exit follow-up.

### Describe who will be providing training and how they were selected. Include trainer’s past performance to demonstrate its ability to operate like or similar high quality training programs that result in employment related outcomes. *The trainer(s) identified here, if a private entity, must be a private business or trade school approved by the Department of Education. Provider must be approved prior to Phase II contract execution or receive written documentation that this is not required.*

### Attach the proposed curriculum.

### Delivery Strategy – In a narrative fashion describe how a specific client will flow through the elements of your program.

### Describe the way your training program integrates work and learning. If you plan to include any work based learning models to engage participants with local employers, please explain here.

### Describe recognized certificate(s)/credential that a successful completer of your program will achieve.

**Customers/Participants**

1. Describe your criteria for participant selection.
2. How will you outreach, recruit customers as well as assess their needs and program fit.

**C. Certificate of Information and Authorization-*Must be completed for your proposal to be considered.***

By submitting this proposal, I hereby certify that to the best of my knowledge all information contained in this proposal is accurate and complete, that this is a valid proposal and that I am legally authorized to submit and to represent this organization.

**Signature (live):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

**Organization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Attachments-***Required except unless noted*

Attachment 1: Non-Collusion Statement

Attachment 2: Exceptions

Attachment 3: Confidentiality and Proprietary Information

Attachment 4: Business References

Attachment 5: Subcontractor Information Form (only if applicable)

Attachment 6: Budget

**Attachment 1**

**RFP NO.:**

**RFP TITLE:**

**DEADLINE TO RESPOND:**

**NON-COLLUSION STATEMENT**

This is to certify that the undersigned Provider has neither directly nor indirectly, entered into any agreement, participated in any collusion or otherwise taken any action in restraint of free competitive bidding in connection with this proposal**, and further certifies that it is not a sub-contractor to another Provider who also submitted a proposal as a primary Provider in response to this solicitation** submitted this date to the State of Delaware, Workforce Development Board.

It is agreed by the undersigned Provider that the signed delivery of this bid represents, subject to any express exceptions set forth at Attachment 2, the Provider’s acceptance of the terms and conditions of this solicitation including all specifications and special provisions.

**NOTE:** Signature of the authorized representative **MUST** be of an individual who legally may enter his/her organization into a formal contract with the State of Delaware, Workforce Development Board.

|  |  |
| --- | --- |
|  | Corporation |
|  | Partnership |
|  | Individual |

 COMPANY NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Check one)

NAME OF AUTHORIZED REPRESENTATIVE

(Please type or print)

SIGNATURE TITLE

COMPANY ADDRESS

PHONE NUMBER FAX NUMBER

EMAIL ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 STATE OF DELAWARE

FEDERAL E.I. NUMBER LICENSE Number

|  |  |  |
| --- | --- | --- |
|  COMPANY CLASSIFICATIONS: CERT. NO.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Certification type(s) | Circle all that apply |
| Minority Business Enterprise (MBE) | Yes No |
| Woman Business Enterprise (WBE) | Yes No |
| Disadvantaged Business Enterprise (DBE) | Yes No |
| Veteran Owned Business Enterprise (VOBE) | Yes No |
| Service Disabled Veteran Owned Business Enterprise (SDVOBE) | Yes No |

[The above table is for informational and statistical use only.]

PURCHASE ORDERS SHOULD BE SENT TO:

ADDRESS

CONTACT

PHONE NUMBER FAX NUMBER

EMAIL ADDRESS

**AFFIRMATION:** Within the past five years, has your firm, any affiliate, any predecessor company or entity, owner,

Director, officer, partner or proprietor been the subject of a Federal, State, Local government suspension or debarment?

YES NO if yes, please explain

**THIS PAGE SHALL HAVE ORIGINAL SIGNATURE AND BE RETURNED WITH YOUR PROPOSAL**

SWORN TO AND SUBSCRIBED BEFORE ME this \_\_\_\_\_\_\_\_ day of , 20 \_\_\_\_\_\_\_\_\_\_

Notary Public My commission expires

City of County of State of

**Attachment 2**

**RFP NO.:**

**RFP TITLE:**

EXCEPTION FORM

Proposals must include all exceptions to the specifications, terms or conditions contained in this RFP. If the provider is submitting the proposal without exceptions, please state so below. The State of Delaware reserves the right to deny any and all exceptions taken to the RFP requirements.

 [ ]  By checking this box, the Provider acknowledges that they take no exceptions to the specifications, terms or conditions found in this RFP.

|  |  |  |
| --- | --- | --- |
| **Paragraph # and page #** | **Exceptions to Specifications, terms or conditions** | **Proposed Alternative** |
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**Note: Provider may use additional pages as necessary, but the format shall be the same as provided above.**

**Attachment 3**

**RFP NO.:**

**RFP TITLE:**

CONFIDENTIAL INFORMATION FORM

[ ]  By checking this box, the Provider acknowledges that they are not providing any information they declare to be confidential or proprietary for the purpose of production under 29 Del. C. ch. 100, Delaware Freedom of Information Act.

|  |
| --- |
| **Confidentiality and Proprietary Information** |
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**Note: Provider may use additional pages as necessary, but the format shall be the same as provided above.**

**Attachment 4**

**RFP NO.:**

**RFP TITLE:**

BUSINESS REFERENCES

List a minimum of three business references, including the following information:

* Business Name and Mailing address
* Contact Name and phone number
* Number of years doing business with
* Type of work performed

Please do not list any State Employee as a business reference. If you have held a State contract within the last 5 years, please provide a separate list of the contract(s).

|  |  |  |
| --- | --- | --- |
| 1.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Provider (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| 2.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Provider (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |
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| 3.  | **Contact Name & Title:**  |  |
|  | **Business Name:**  |  |
|  | **Address:**  |  |
|  |  |  |
|  | **Email:**  |  |
|  | **Phone # / Fax #:**  |  |
|  | **Current Provider (YES or NO):**  |  |  |
|  | **Years Associated & Type of Work Performed:**  |  |

**State of Delaware personnel MAY NOT BE USED as references.**

Attachment 5

SUBCONTRACTOR INFORMATION FORM

|  |
| --- |
| **PART I – STATEMENT BY PROPOSING PROVIDER** |
| 1. RFP NO.**LAB 18 001-ADULTTRNG** | 2. Proposing Provider Name: | 3. Mailing Address |
| 4. SUBCONTRACTOR |  |
| a. NAME | 4c. Company OSD Classification:Certification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| b. Mailing Address: | 4d. Women Business Enterprise [ ]  Yes [ ]  No4e. Minority Business Enterprise [ ]  Yes [ ]  No4f. Disadvantaged Business Enterprise [ ]  Yes [ ]  No4g. Veteran Owned Business Enterprise [ ]  Yes [ ]  No4h. Service Disabled Veteran Owned Business Enterprise [ ]  Yes [ ]  No |
| 5. DESCRIPTION OF WORK BY SUBCONTRACTOR |
| 6a. NAME OF PERSON SIGNING | 7. BY (*Signature)* | 8. DATE SIGNED |
| 6b. TITLE OF PERSON SIGNING |
|  **PART II – ACKNOWLEDGEMENT BY SUBCONTRACTOR** |
| 9a. NAME OF PERSON SIGNING | 10. BY (*Signature*) | 11. DATE SIGNED |
| 9b. TITLE OF PERSON SIGNING |

  **\* Use a separate form for each subcontractor**

|  |  |
| --- | --- |
|  | **TOTAL** |
| 1. Staff Salaries
 |  |
| 1. Staff Fringe Benefits
 |  |
| 1. SUBTOTAL (Lines 1+2)
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| 1. Supportive Services to Participants
 |  |
| 1. Rent (inc. cost per sq. ft./hr. rates)
 |  |
| 1. Custodial Services
 |  |
| 1. Utilities (List as a % of Annual Expense)
 |  |
| 1. Heat/AC
 |  |  |  |
| 1. Phone
 |  |  |  |
| 1. Electric
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| 1. Other
 |  |  |  |
| 1. Consumable Office Supplies
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| 1. Postage
 |  |
| 1. Equipment and Furniture Purchase
 |  |
| 1. Equipment Rental
 |  |
| 1. Tuition
 |  |
| 1. Entrance Fees
 |  |

|  |  |
| --- | --- |
| 1. Training Materials
2. Books
3. Software
4. Other (specify)
5. Total
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| 1. Printing/Advertising
 |  |
| 1. Travel
2. Student
3. Staff
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| 1. Staff Training
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| 1. Participant Payments (Wages. OJT Payments, etc...)
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| 1. Participant Fringes
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| 1. Insurance:
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| 1. Professional Services: (List)
 |  |
| 1. Overhead/Indirect for Parent Organization:
 |  |
| 1. Profit:
 |  |
| 1. Other: (Please specify)
 |  |
| 1. Other: (Please specify)
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|  |  |
| --- | --- |
| 1. **TOTAL**
 |  |

**EMPLOYEE LISTING**

**SALARY AND FRINGE EXPENSES**

AREA OF TRAINING:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEAR: \_\_\_\_\_\_\_\_\_

ORGANIZATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**LIST EVERY EMPLOYEE BY TITLE**

**ADD ROWS AS NEEDED**

**USE ADDITIONAL PAGES TO LIST EACH EMPLOYEE NUMERICALLY**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| POSITION | DATES OF EMPLOYMENT HOURS PER WEEK (if seasonal give # of weeks and hourly rate) (If part-time, indicate hourly rate) |  | SALARY | FRINGE | TOTAL | FUNDED STAFF HOURS |
| Person #1 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |
| Person #2 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |
| Person #3 |  | THIS PROGRAM  |  |  |  |  |
|  |  | OTHER |  |  |  |  |

Organization\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of Training \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**BUDGET BACK-UP PAGE**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| LINENUMBER | ITEM | NUMBER OF EACH | AMOUNT | EXPLANATION/REMARKS |
|  |  |  |  |  |
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***SUPPORTIVE SERVICE TO PARTICIPANTS***

CONTRACTOR:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TYPE OF TRAINING\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL AMOUNT OF SUPPORTIVE SERVICES: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CLIENTS MUST NOT RECEIVE CASH. VOUCHERS ARE TO BE USED FOR GOODS AND SERVICES) CONTRACTORS MUST MAINTAIN A CUMULATIVE LOG TO DOCUMENT CLIENTS RECEIVED SUPPORTIVE SERVICE(S). AT A MINIMUM THIS LOG MUST INCLUDE CLIENT NAME, STAFF AND CLIENT SIGNATURE, AMOUNT OF SUPPORTIVE SERVICES GIVEN, AND VENDOR.

Furthermore, contractors will only be reimbursed for direct benefits they have given to client.

TYPE OF PAYMENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EXPLANATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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