**ATTACHMENT**

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| **For Board Use Only** |  | |
| Received By: | Date: | Time**:** |

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| **Application**  **COVID-19 Short-term Training Services** |

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| **Vendor’s Information** | |
| **Full Legal Name of Vendor:** |  |
| **Mailing Address:** |  |
| **Street Address (if different):** |  |
| **City/State/Zip:** |  |

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| --- | --- |
| **Vendor’s Authorized Representative** | |
| **Name:** |  |
| **Title:** |  |
| **Telephone Number:** |  |
| **Fax Number:** |  |
| **E-mail Address:** |  |

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| **Vendor’s Contact Person:** | |
| **Name:** |  |
| **Title:** |  |
| **Telephone Number:** |  |
| **Fax Number:** |  |
| **E-mail Address:** |  |

**Vendor’s Federal Employer Identification Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Is this a Historically Underutilized Business (HUB)?** **YES** **NO**

Is your program regulated by a State Agency such as the Texas Workforce Commission Career Schools and Colleges or the Texas Higher Education Coordinating Board?  YES  NO

**NOTE: If you answered NO to the question above, please attach a copy of your most recently audited financial statement.**

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| **Vendor Type – please check all that apply** |  |
| Charitable/Faith  Proprietary  Community College  Based Org. School  Community  University **\_\_\_Public** **\_\_\_Private**  Other  **Based Org.**  Nature of Organization  **Corporation**  **For Profit**  **Non-Profit**  Sole Proprietorship  Partnership | |

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| --- | --- |
| **Type of Service Offering – please check all that apply** | |
| Disinfectant Specialist  Contact Tracing/Investigation  Other COVID Related  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Other COVID Related  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Program Information |

***A separate application must be submitted for each program or service offering.***

Provider Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Program Address/Location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Business Hours: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Program Web Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your facility meet the requirements of the American with Disabilities Act?  YES  NO

Are the facilities easily accessible by bus?  YES  NO

Do you maintain liability insurance? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Amount of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If not will you provide? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Provider Background / Experience** |

**Has your organization been providing the stated educational/training services for at least one year?**  **YES**  **NO**

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| **Proposed Program** |

**1. PLEASE COMPLETE APPLICABLE LINES for the program, course or activity:**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Title | **CIP Code[[1]](#footnote-1)** | Total Hours of instruction | | Avg Class Size | Instructor to Student Ratio | No. of Participants in past 12 months | No. of Completers in past 12 months | |
|  |  | **Classroom** | **Lab** |  |  |  |  |
|  |  |  |  |  |  |  |  |

**2. Attach documentation to include the following:**

1. **The type of certificate or other credential issued upon completion of the program, course or activity.**
2. **A statement as to methods and venues used to make others aware of your programs and activities.**
3. **The curriculum outline (or attach a syllabus, course or program catalog, or brochure describing the program) including a description of the books, supplies, tools, equipment or specialized clothing or other items used in the program for which costs are included in the budget.**
4. **Outline of entry level requirements and/or characteristics of the population served, especially in regards to special populations with multiple barriers and/or disadvantaged populations.**
5. **Expected outcomes and how these are documented or measured (for example, pre- and post- testing).**
6. **Teacher’s Credentials and Resume (Not applicable for institutions subject to State regulatory authorities such as the Texas Workforce Commission Career Schools and Colleges Division or the Texas Higher Education Coordinating Board.**
7. **Copy of refund policy including procedures in place in the event that a participant drops out of the program prior to completion. Policy may be in a tiered format to indicate refundable or non-refundable charges by time or category.**
8. **Attendance Policy**

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| **Cost Information** |

**1. Proposed costs including budget details on how the cost was determined. The following are sample budget categories, but costs are not limited to these:**

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| --- | --- | --- | --- | --- |
| **REQUIRED PROGRAM FEES** | | | | |
| **Total Cost Per Participant** | **$** | | **Additional Costs** | |
|  | | | **Books** | **$** |
| **Equipment** | **$** |
| **Supplies** | **$** |
| **Tools** | **$** |
| **Other** | **$** |
| **OPTIONAL FEES:** | | | | |
| **Item** | | **Cost** | **Item** | **Cost** |
|  | | **$** |  | **$** |
|  | | **$** |  | **$** |

**All books, equipment, supplies, tools & uniforms purchased by Workforce Solutions Cameron for customers will either become the property of Workforce Solutions Cameron or the customer, not the training provider.**

**NOTE: Workforce Solutions Cameron cannot pay for counseling that is administered by a medical professional in a medical setting.**

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| **Certification of Applicant** |

**The Applicant/Service Provider hereby submits an application to** Workforce Solutions Cameron. **This is an offer to provide the stated education and training services for eligible participants funded under the workforce programs and other State and federal programs/contracts administered by Workforce Solutions Cameron.**

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| **Authorized Signatory Name and Title:** | **Date:** |
|  |  |

**2. FINANCIAL DOCUMENTATION**

**Applicants that are not regulated by a State Regulatory Agency such as the Texas Workforce Career Schools and Colleges or the Texas Higher Education Coordinating Board are required to provide evidence of financial stability prepared by a certified public accountant. Is documentation of financial stability attached?**

**Yes**  **No**

***A separate application must be submitted for each program, service or activity proposed.***

1. If applicable, provide the Classification of Instructional Program Code. CIP codes are published by the National Center for Education Statistics and additional information can be found at http://nces.ed.gov/pubs2002/cip2000/. [↑](#footnote-ref-1)