

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

*Proposal for Incumbent Worker Training  
Under the Workforce Investment 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)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**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 Investment Act of 1998 **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 \_\_\_\_\_

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10. Weekly Schedule:

<b>Days</b>	<b>Start and End Times</b>
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

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

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12. Please describe the type of certification that will be obtained at the completion of training. (if applicable)

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

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

15. Is this program for a “demand occupation” in the Territory based on the list of demand occupations attached? \_\_\_\_\_ Yes \_\_\_\_\_ No

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

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

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17. Kindly attach the course curriculum and current resumes of the instructors.

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### **D. DEMONSTRATED PERFORMANCE**

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

*If you do not have some of the past performance data requested in questions 4-6 or if you did not provide training services to a particular population, leave that section blank. Attached to this solicitation is a brief description of the performance measures that you will be required to collect this year in order to be considered for future participation with this program.*

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)

\_\_\_\_\_  
Name and Mailing Address of Contact Person \_\_\_\_\_  
\_\_\_\_\_

Amount of Funds Received \$ \_\_\_\_\_

4. Adults (aged 18 and over)/Dislocated Workers Served

Total number served: \_\_\_\_\_

Total number who successfully completed training: \_\_\_\_\_

Total number who received a credential \_\_\_\_\_

Total number placed in full-time training-related jobs: \_\_\_\_\_

Average hourly wage at placement: \$ \_\_\_\_\_

Total number who were still employed six (6) months after placement \_\_\_\_\_

Average hourly wage six (6) months after placement: \_\_\_\_\_

5. Youth Services (aged 14-21)

Total number served: \_\_\_\_\_

Total number who successfully completed training: \_\_\_\_\_

Number completed major level of education (HS diploma/GED): \_\_\_\_\_

Number gained basic skills, work readiness skills and/or occupational skills \_\_\_\_\_

Number who continued on for post-secondary education or training, joined the military or entered a registered apprenticeship: \_\_\_\_\_

Total number who received a credential \_\_\_\_\_

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Total number placed in full-time training-related jobs: \_\_\_\_\_

Average hourly wage at placement: \$ \_\_\_\_\_

Average hourly wage six (6) months after placement: \_\_\_\_\_

Total number who were still employed six (6) months after placement \_\_\_\_\_

6. If you have not had past experience in providing training services, describe/explain what qualifies you to receive funds for this purpose: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**E. 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.

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Attachments: Background Information  
Demand Occupations

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## **F. BUDGET INFORMATION**

### GRANT COST ANALYSIS

The proposing agency must submit a complete budget including, but not limited to, the form attached to this Request for Proposal. 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.

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## 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
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**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)

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**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*

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**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** \$ \_\_\_\_\_

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**TOTAL PROGRAM BUDGET** \$ \_\_\_\_\_  
*(Total Administrative + Total Training)*

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**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.*