

Incumbent Worker Training Application

SECTION 1. <i>Business Information</i>			
Business Name:			
Authorized Business Representative:		Title:	
Phone:	Ext.:	Fax:	
Email:		Website Address:	
Street/Mailing:			
City:	9 Digit Zip Code:	County:	
For which business location are you seeking funding?			
Date of Inception:		Years in Business:	
Total Number of Full-time Employees:		Total Number of Part-time Employees:	
Total Number of Full-time Employees at this Business Location:		Total Number of Part-time Employees at this Business Location:	
Legal Structure of Business:	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partnership	<input type="checkbox"/> Corporation (Designation:)
Employer's Federal ID #:		Unemployment Comp ID #:	
South Carolina Sales Tax Reg. #:		NAICS Code:	
Is your business current on all State of South Carolina tax obligations?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Has your business received IWT funding before?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please indicate the training period:			
Is your business receiving/applying for other public training/consulting funds?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please identify the funding source and type of training/consulting services:			
Has there been a layoff at this site within the last 12 months?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes:	<input type="checkbox"/> Temporary Layoff Number affected:	<input type="checkbox"/> Permanent Layoff Number affected:	
Has the business or part of the business relocated operations within the last 120 days?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes:	Relocated from:	Relocated to:	Date of Relocation:
Does your business use SC Works services?		<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, please check all applicable services:	<input type="checkbox"/> List Job Openings <input type="checkbox"/> Job Fairs <input type="checkbox"/> Testing & Assessment	<input type="checkbox"/> Mass Hires <input type="checkbox"/> Candidate Search <input type="checkbox"/> Other:	<input type="checkbox"/> On-the-Job Training (OJT) Please note: employees cannot participate in both WIOA funded OJT and IWT simultaneously.

Please describe your business, product(s) and/or service(s):

Our business is minority owned. (Please check one of the boxes below)

- | | |
|--|--|
| <input type="checkbox"/> Women owned | <input type="checkbox"/> Asian/American owned |
| <input type="checkbox"/> African/American owned | <input type="checkbox"/> Native/American owned |
| <input type="checkbox"/> Hispanic/American owned | <input type="checkbox"/> Other minority owned (specify): |

Amount of Funding Requested:	Number of Trainees:
Start Date:	End Date:

Type(s) of training proposed (ex: Maintenance, Quality, Computer, etc.):

How did you learn about Incumbent Worker Training?

SECTION 2. Eligibility Criteria

Please check all boxes that apply. Attach additional sheets if necessary.

Incumbent worker training is necessary due to:

- | | |
|--|---|
| <input type="checkbox"/> Business expansion | <input type="checkbox"/> Changing industry requirements |
| <input type="checkbox"/> Retooling of our business process | <input type="checkbox"/> The introduction of new services/product lines |
| <input type="checkbox"/> New organizational structuring | <input type="checkbox"/> Avert a layoff |
| <input type="checkbox"/> New technology | <input type="checkbox"/> Competitive business expansion |

Please provide an explanation of the selections above:

The proposed training would:

- | | |
|---|--|
| <input type="checkbox"/> Significantly increase employee skills | <input type="checkbox"/> Save jobs within our business (How many?) |
| <input type="checkbox"/> Result in employee wage increases | <input type="checkbox"/> Help prevent business relocation |

Please provide an explanation supporting how the proposed training would accomplish the selections above:

SECTION 3. Training Provider Information:

If known, please answer the following.

Name of Training Provider:	Provider's Federal ID #:
-----------------------------------	---------------------------------

Name of Training Provider Representative:**Address:**

City:	State:	ZIP:
--------------	---------------	-------------

Phone:	Fax:
---------------	-------------

SECTION 4. Training Project Information

Up to 6 training programs may be requested on each application. If you would like to request more, please complete additional applications as necessary. Please list in order of priority for your business.

TRAINING #1

Name of Training:

Training Description:

Training Institution/School:

Address:

City:

State:

Zip:

Phone:

Name of Trainer (if in-house):

Anticipated training dates:

Projected Number of Hours
of Training:

Number of Trainees:

Job Title(s) and Length(s) of Employment:

Certification Earned:

BUDGET

Instructor Wages/Tuition:

*Materials/Supplies/Textbooks:

*Other Costs:

TOTAL COST:

*Please itemize costs related to materials, supplies, textbooks, and other costs here:

TRAINING #2

Name of Training:

Training Description:

Training Institution/School:

Address:

City:

State:

Zip:

Phone:

Name of Trainer (if in-house):

Anticipated training dates:

Projected Number of Hours
of Training:

Number of Trainees:

Job Title(s) and Length(s) of Employment:

Certification Earned:

BUDGET

Instructor Wages/Tuition:

*Materials/Supplies/Textbooks:

*Other Costs:

TOTAL COST:

*Please itemize costs related to materials, supplies, textbooks, and other costs here:

TRAINING #3		
Name of Training:		
Training Description:		
Training Institution/School:		
Address:		
City:	State:	Zip:
Phone:		
Name of Trainer (if in-house):		
Anticipated training dates:		
Projected Number of Hours of Training:	Number of Trainees:	
Job Title(s) and Length(s) of Employment:		
Certification Earned:		
BUDGET	Instructor Wages/Tuition:	*Materials/Supplies/Textbooks:
	*Other Costs:	TOTAL COST:
*Please itemize costs related to materials, supplies, textbooks, and other costs here:		

TRAINING #4		
Name of Training:		
Training Description:		
Training Institution/School:		
Address:		
City:	State:	Zip:
Phone:		
Name of Trainer (if in-house):		
Anticipated training dates:		
Projected Number of Hours of Training:	Number of Trainees:	
Job Title(s) and Length(s) of Employment:		
Certification Earned:		
BUDGET	Instructor Wages/Tuition:	*Materials/Supplies/Textbooks:
	*Other Costs:	TOTAL COST:
*Please itemize costs related to materials, supplies, textbooks, and other costs here:		

TRAINING #5		
Name of Training:		
Training Description:		
Training Institution/School:		
Address:		
City:	State:	Zip:
Phone:		
Name of Trainer (if in-house):		
Anticipated training dates:		
Projected Number of Hours of Training:	Number of Trainees:	
Job Title(s) and Length(s) of Employment:		
Certification Earned:		
BUDGET	Instructor Wages/Tuition:	*Materials/Supplies/Textbooks:
	*Other Costs:	TOTAL COST:
*Please itemize costs related to materials, supplies, textbooks, and other costs here:		

TRAINING #6		
Name of Training:		
Training Description:		
Training Institution/School:		
Address:		
City:	State:	Zip:
Phone:		
Name of Trainer (if in-house):		
Anticipated training dates:		
Projected Number of Hours of Training:	Number of Trainees:	
Job Title(s) and Length(s) of Employment:		
Certification Earned:		
BUDGET	Instructor Wages/Tuition:	*Materials/Supplies/Textbooks:
	*Other Costs:	TOTAL COST:
*Please itemize costs related to materials, supplies, textbooks, and other costs here:		

SECTION 5. Training Program Budget

Please note: businesses/consortia must contribute to the cost of the training project, with minimum contributions of:
(1) 10 percent of the cost for business locations or consortia with no more than 50 employees
(2) 25 percent of the cost for business locations or consortia with more than 50 employees, but no more than 100 employees
(3) 50 percent of the costs for a business location or consortia with more than 100 employees

BUDGET CATEGORY	TRAINING ASSISTANCE REQUESTED	BUSINESS MATCHING CONTRIBUTION	TOTAL
INSTRUCTOR WAGES/TUITION			
MATERIALS/SUPPLIES/ TEXTBOOKS			
WAGES PAID WHILE ATTENDING TRAINING*	XXXXXXXXXXXXXXXXXXXX		
OTHER EMPLOYER CONTRIBUTIONS TO THE COST OF TRAINING	XXXXXXXXXXXXXXXXXXXX		
OTHER COSTS (describe)			
TRAVEL	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXX
TOTAL			XXXXXXXXXXXXXXXXXXXX

***Note: Wages paid to employees while attending training may be used for the business's /training consortium's contribution to the cost of training**

SECTION 7. Certification by Authorized Business Representative

I hereby certify that I am an authorized representative of the business named above, with the authority to commit the business to legally binding contracts and agreements. I further certify that the information given as part of and attached to this application is true and accurate. I am aware that any false information or intended omissions may subject me to civil or criminal penalties for filing of false public records and/or forfeiture of any funds approved through this program.

This application does not constitute a contractual agreement. If any portion of the application is approved, a formal agreement between parties will be executed to obligate funds for the approved training. Training may not start prior to the effective date of the agreement.

Signature:	Title:
Print Name:	Date: