

**NORTHERN TIER WORKFORCE INVESTMENT AREA
WORKFORCE INVESTMENT BOARD**

Craig Harting
Chairman

Frank Thompson
Workforce Director

Dear Northeast PA Health Care Industry Leaders:

In response to Governor Rendell's JOB READY PENNSYLVANIA initiative the consortia of Workforce Investment Boards of Lackawanna, Luzerne/Schuylkill, Northern Tier and Pocono Counties has applied for and received an Industry Partnership Worker Training Grant in the amount of **\$150,000.00**. These dollars are dedicated to improving the skill levels of incumbent workers while promoting advancement opportunities. We invite your company to inquire about and/or apply for funding.

Fill out the attached Application for Funding in its entirety, providing all requested information and documentation. Applications can also be found at www.northerntier.org. Submit completed application to: **Sherry Felten at NTRPDC, 312 Main Street, Towanda, PA, 18848 or fax to 570-265-1533. Applications may also be sent electronically to felten@northerntier.org.**

Training applications for consortia-based or multiple employer training programs will be given first consideration. Trainings to advance skill levels in the following areas will be considered.

- Direct Care Worker including Home Health Aide, CNA, LPN, RN, BSN
- Workforce Retention/Workforce Supervision
- Alzheimer's Dementia
- Personal Care Home Administration
- Cultural Awareness/Diversity
- Advanced Health Safety
- EMT/Paramedic
- Dental Assistant
- Pharmacy Tech
- Phlebotomist
- Physical Therapy
- Radiological
- Surgical Technician
- Diagnostic Medical Sonographers

Non-eligible trainings include:

- Basic skills or entry level training that does not result in higher skill levels
- Training supported by existing programs i.e. WIA, TANF, CJT, WEDNet and PA CareerLink Services
- Articulation Agreements
- Proprietary training owned by a single business
- Basic health and safety training (OSHA-10)

Employers approved for funding are required to forward a signed MOA and a check for 25% of the total training cost within 30 days of notification of award AND prior to the start of training to the Northern Tier Regional Planning & Development Commission. Failure to do so will result in the cancellation of the funding award and the applicant will be responsible for covering the costs of the training in its entirety. Training must be completed by June 30, 2010.

If you have any questions, comments or would like assistance in this process, please Sherry Felten, at (570) 265-1516 or e-mail felten@northerntier.org

Sincerely,

Frank Thompson
Workforce Director

Health Care Industry Partnership Worker Training

Last updated: 1/27/2010 (2)

APPLICANT DATA

Company Name:

Contact Person:

Contact Person's Title:

Address:

Phone:

Fax:

Email:

Company Website:

COMPANY DATA

Size of Company:

#Employees at Location: _____

#Employees Worldwide: _____

Type of Company Ownership:

Union Affiliation:

Location of other Division, Facilities or Headquarters:

Federal Employer Identification Number (FEIN):

Meets ADA Requirements Yes or No

Product/Service Description:

Industry Code (NAIC):

(North American Industry Classification Code)

Interested in Partnership member activities (Check all that apply):

Employer Meeting Host, **Employer Panel,** **Employer Tour,** **Youth Activities**

Resources utilized for recruiting:

PA Career Link, **Newspaper only,** **Temp. Agencies,** **H.R. Firms** **Other**

Have you applied for or received WEDnet funding? Yes **No** **(www.wedpa.com)**

What type of training are you applying for? (Briefly describe)

Is this consortium training? YES NO

Is this company specific training? YES NO

Is this third party vendor training? YES NO

Number of Employees to be Trained _____

Training Begin Date _____

Training End Date _____

Briefly describe your training needs and the impact of this training initiative - (wage increases, job creation, employee skill enhancement or advancement, process improvement, etc.)

Identify the training provider(s) or education institution(s) that will provide this training:

(Note: A copy of the training contract or training syllabus must be included with this application)

Trainer Provider: _____

Training Provider Contact: _____

Title of Training: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Training Grants are required to provide documentation of a "1 to 1" match. For each dollar of training funds requested, 25% will be a cash contribution on your part (your company pays 25% of the total training costs) and the remaining 75% will be in-kind contribution (resources your company expended to have employees attend the training). Below is an example:

TRAINING COST BREAKDOWN EXAMPLE:

Total Training Cost = \$ 10,000

Grant Subsidy Request	Company Match
100% of Total Cost = <u>\$10,000</u>	Cash Contribution (25%) = <u>\$2,500</u> In Kind Contribution = <u>\$7,500</u> <i>Employee costs (wages/benefits) to attend training, computer and equipment usage, use of facilities, etc. represents in-kind contributions.</i>
TOTAL GRANT REQUEST: \$10,000	TOTAL COMPANY MATCH: <u>\$10,000</u> <i>“Company Match” must <u>equal OR exceed</u> the “Total Grant Request”.</i>

TRAINING COST BREAKDOWN (Please Complete)

Total Training Cost = \$

Grant Subsidy Request	Company Match
100% of Total Cost = 	Cash Contribution (25%) = In Kind Contribution = <i>Please detail employee costs (wages/benefits) to attend training, computer and equipment usage, use of facilities, etc. that will represent an in-kind contribution. In-kind contributions must equal or EXCEED the total Grant Request.</i>
TOTAL GRANT REQUEST: \$ 	TOTAL COMPANY MATCH: \$ <i>“Company Match” must <u>equal OR exceed</u> the “Total Grant Request”.</i>

To document the in-kind contribution, please provide the information – in the format below:

Please place on your company letterhead.

Address

Phone/fax number

Date:

As a requirement to accepting grant funds for training through the _____ Industry Partnership Worker Training Grant Program, documented below is paid employee(s) work release time as in-kind contribution:

Training Course Selected: _____

Date of Training: _____

Of Employees X Hrs of Training X Dollars = Paid work release time
(Away from work) (Salary, benefits, travel)

_____ X _____ X \$_____ = \$_____

In-Kind Contribution

= \$_____

Signature

Date _____

Title

TRAINING ROSTER: All fields are required to be completed for each employee. Social Security Numbers are required by the PA Department of Labor and Industry. Social Security Numbers must be provided before training funds are released.

Company Name:

Title of Training:

Signature of Authorized Representative:

Mandatory Info:	Trainee #1	Trainee #2	Trainee #3	Trainee #4	Trainee #5	Trainee #6
Name (first & last)						
SS#						

Optional Demographic Information

Current Occupational Title						
Occupational Title After Completion of the Training						
Male or Female						
Ethnicity: 1.) Hispanic or Latino 2.) Not Hispanic or Latino						
Race: See legend below						
Trainee Wage Gain Immediately After the Completion of Training? Answer Y/N. If YES, List increase amount per hour.						
Trainee Wage Gain 6-12 Months After the Completion of the Training? Answer Y/N. If YES, list increase amount per hour.						
Skill Enhancement? Answer Y/N – if YES, briefly explain.						
Career Advancement? Answer Y/N – If YES, briefly explain.						

1) American Indian

2) Asian

3) Black/African American

4) Native Hawaiian or Pacific Islander

5) White

6) Two or more

*****Please add additional sheets as required by the number of employees to be trained.***

Mandatory Info:	Trainee #7	Trainee #8	Trainee #9	Trainee #10	Trainee #11	Trainee #12
Name (first & last)						
SS#						

Optional Demographic Information

Current Occupational Title						
Occupational Title After Completion of the Training						
Male or Female						
Ethnicity: 1.) Hispanic or Latino 2.) Not Hispanic or Latino						
Race: See legend below						
Trainee Wage Gain Immediately After the Completion of Training? Answer Y/N. If YES, List increase amount per hour.						
Trainee Wage Gain 6-12 Months After the Completion of the Training? Answer Y/N. If YES, list increase amount per hour.						
Skill Enhancement? Answer Y/N – if YES, briefly explain.						
Career Advancement? Answer Y/N – If YES, briefly explain.						

**ALL HEALTH CARE APPLICATIONS FOR TRAINING GRANT SUBSIDY
MUST BE FORWARDED TO:**

**Northern Tier Regional Planning & Development Commission
Attn: Sherry Felten
312 Main Street
Towanda, PA 18848**

**ALL HEALTH CARE CHECKS (25% COST OF TRAINING)
ARE PAYABLE TO:**

Northern Tier Regional Planning & Development Commission