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**CareerSource Florida  
INCUMBENT WORKER TRAINING PROGRAM  
APPLICATION  
PY 2015-2016**

IWT # \_\_\_\_\_

\_\_\_\_\_  
(Business name as it would appear on contract)

**CareerSource Florida**

1580 Waldo Palmer Lane, Suite 1

Tallahassee, Florida 32308

Phone: (850) 921-1119

An equal opportunity employer program.

Auxiliary aids and devices are available upon request to individuals with disabilities.

<http://www.careersourceflorida.com/>

**Incumbent Worker Training Program Grant Application – 2015/2016**  
**SECTION 1. Company Information All fields in Section I are Required**

|  |
|--|
| <i>Admin Only</i><br>IN _____<br>IWT # _____<br>Region # _____ |
|--|

|  |   |   |
|--|---|---|
| Company Name:  |   |   |
| Street/Mailing Address:  |   |   |
| Physical Address:  |   |   |
| City:  | Zip:  | County:   |
| Company Contact Person:  |   | Title:  |
| Phone:   |   | Fax:  |
| E-Mail Address:  |   | Company URL:  |
| Alternate Contact Person:  |   | Title:  |
| Phone:   | Ext:  | Fax:  |
| E-Mail Address:  |   | Company URL:  |
| Is your company a subsidiary of another company or affiliated with a parent company? Yes <input type="checkbox"/> No <input type="checkbox"/><br>If "Yes", please provide the following information about the corporate office/parent company, if different from above, or indicate "SAME" |   | Parent Company Name:<br>Street/Mailing Address:<br>City/State:<br>Company Contact Person:<br>Phone:                      Ext:                      Fax:<br>Company Email Address: |
| *Date of Operation is pertinent to the location of the Florida Business. Verification of business operation will be requested if the Florida Department of State shows business filing date to be less than 1 year and a day.  |   |   |
| *Years in Operation in the state of Florida  |   |   |
| Date of Inception:   | *Years in Business:   | Total # Full-time Employees at this location:   |
| Legal Structure of Business:   | <input type="checkbox"/> Sole Proprietor <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation<br><input type="checkbox"/> Non-profit <input type="checkbox"/> Leased <input type="checkbox"/> Other: |   |
| Employer's FEIN#:  | Unemployment Comp ID #:   |   |
| Florida Sales Tax Reg. ID #:   | Primary NAICS   | Secondary NAICS   |
| Is your company current on all State of Florida tax obligations? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| Please estimate the total amount your company will spend on training in 2012/2013:   |   |   |
| Is your company receiving/applying for local Employed Worker Training Funds (EWT)? <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| I or this company certify having NOT received a federal debarment notice <input type="checkbox"/> Yes, certify having NOT received one <input type="checkbox"/> No   |   |   |
| Is your company receiving/applying for any other federal training funds? If yes please list the name of the Program or Type of Grant <input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |
| Name of Grant:   | Amount of Award:  |   |
| Year Award was received:   | Year training was complete:   |   |
| Is your company currently receiving Federal funding from other sources that require the company to comply with The Federal Single Audit Act? (please refer to IWT guidelines concerning this issue) <input type="checkbox"/> Yes <input type="checkbox"/> No                               |   |   |
| If yes, please state the source(s) and the \$ amount(s):   |   |   |
| Description of your business, product(s) and/or service(s):  |   |   |

|   |  |
|---|--|
| Amount of Grant Request:<br>(must equal row 11 column C on budget page) | Number of FT Employees to be trained:<br>(must be Florida residents) |
| Training start date: (on or after 7/1/14)                               | Training end date:   |
| If this company is minority-owned, please check the appropriate box:    |  |
| <input type="checkbox"/> Native-American owned                          | <input type="checkbox"/> African-American owned                      |
| <input type="checkbox"/> Asian-American owned                           | <input type="checkbox"/> Women-owned                                 |
| <input type="checkbox"/> Hispanic-American owned                        | <input type="checkbox"/> Other minority-owned (specify):             |
| Our company is located in:  |  |
| <input type="checkbox"/> Distressed inner-city area                     | <input type="checkbox"/> Brownfield Resolution #                     |
| <input type="checkbox"/> HUB Zone                                       | <input type="checkbox"/> Enterprise Zone (provide EZ Number):        |
|   | <input type="checkbox"/> Rural County/Rural Area                     |

**SECTION 2. Training Provider Information** (This information is needed for each **private** training provider in addition to their resume)

|                                       |                                  |  |  |   |
|---------------------------------------|----------------------------------|--|--|---|
| The training providers will be:       |                                  |  | <input type="checkbox"/> Public training institution         | <input type="checkbox"/> Private training institution |
|                                       |                                  |  | <input type="checkbox"/> Company employee (No resume needed) | <input type="checkbox"/> Private instructor           |
| Training will be delivered:           | <input type="checkbox"/> On-site | <input type="checkbox"/> At the training institution | <input type="checkbox"/> At a remote location                |   |
| Name of Training Provider(s):         |                                  |  |  |   |
| Name of Training Provider Contact:    |                                  |  | Phone:   |   |
| Address:                              |                                  |  |  |   |
| City:                                 | State:                           | Zip:   |  |   |
| E-Mail Address:                       |                                  |  |  |   |
| The training providers will be:       |                                  |  | <input type="checkbox"/> Public training institution         | <input type="checkbox"/> Private training institution |
|                                       |                                  |  | <input type="checkbox"/> Company employee(No resume needed)  | <input type="checkbox"/> Private instructor           |
| Training will be delivered:           | <input type="checkbox"/> On-site | <input type="checkbox"/> At the training institution | <input type="checkbox"/> At a remote location                |   |
| Name of Training Private Provider(s): |                                  |  |  |   |
| Name of Training Provider Contact:    |                                  |  | Phone:   |   |
| Address:                              |                                  |  |  |   |
| City:                                 | State:                           | Zip:   |  |   |
| E-Mail Address:                       |                                  |  |  |   |

**\*\*If more Training Provider Information boxes are needed, please feel free to copy and paste additional boxes to this page and additional pages.**

### **SECTION 3. Training Project Information**

Description of the proposed training project—provide number of trainees, job titles, departments, broken out by type of training, number of hours of training, training provider, cost of instruction/tuition, any resulting certifications, etc. List the number of manuals needed for each course plus the cost of each. ***Please use only the format listed below for submission of your training requests – no spreadsheets. You may create additional pages that include section 3.***

Examples:

***Vendor Training Provider***

1. (5) Plastics Operators  
Production Department  
Course Name- How to make plastic/ # of hours—28 hours  
Training Provider: Society of Plastics Industry via satellite downlink at company site  
\$500 per trainee = \$2,500.00 (course cost)  
National Certification in Plastics—NCP Certified Operator

***Internal Training Provider/Company Employee***

2. (10) Managers  
Production, Quality Assurance, and Accounting Departments  
Course Name –New Vision Tracking Software for Manufacturers  
Training Provider: Company employee  
(4) sessions, 6 hours each=24 hours x\$35/hr (maximum)=\$840 (course cost)  
No certification  
10 New Vision training manuals @ \$30 each=\$300

## SECTION 4. Training Program Budget

Note: Training funds cannot be used to reimburse any training costs incurred before the grant is approved. Please take this into account when developing your budget timeline.

| A.<br>BUDGET CATEGORY   | B.<br>TOTAL COSTS | C.<br>IWT FUNDS REQUESTED  | D.<br>EMPLOYER CONTRIBUTION*<br>(B-C) |
|---|-------------------|----------------------------|---------------------------------------|
| <b>1. Instructor Wages/Tuition <span style="color: red;">Required Field</span></b><br><b>(This information should reconcile with Section 3, Training Project Description.)</b><br>Example: Column B should be the total cost of the training in Section 3:<br>1) How to make Plastic \$500 x (5) = \$2,500<br>2) New Visions \$35/hr x 24 hrs = \$840<br>TOTAL COSTS = <b>\$3,340</b> |                   |                            |                                       |
| <b>2. Curriculum Development</b> (include calculation of costs in section III)  |                   |                            |                                       |
| <b>3. Manuals/Textbooks</b> (itemize in section III )<br>Example: Column B should be the total cost of the manuals in Section 3:<br>(10) New Vision Manuals @ \$30 each = <b>\$300</b>  |                   |                            |                                       |
| <b>4. Training Equipment Purchase</b> (must be employer contribution)   |                   | Cannot fund with IWT grant |                                       |
| <b>5. Other Costs</b> (i.e. copies, DVD's,)<br>a)<br>b)   |                   |                            |                                       |
| <b>6. Facility Usage</b> (if some training takes place at company site, then <span style="color: red;">Required Field</span> )  |                   | Cannot fund with IWT grant |                                       |
| <b>7. Travel, Food, Lodging</b> (if some training takes place off site, then <span style="color: red;">Required Field</span> )  |                   | Cannot fund with IWT grant |                                       |
| <b>8. Sub Total</b>   |                   |                            |                                       |
| <b>9. Trainee Wages <span style="color: red;">Required Field</span></b><br>(including benefits)   |                   | Cannot fund with IWT grant |                                       |
| <b>10. Indirect Costs</b>   |                   | Cannot fund with IWT grant |                                       |
| <b>11. TOTALS <span style="color: red;">Required Field</span></b>   |                   |                            |                                       |

**IWT Cost per Trainee = Line 11, Column C divided by Number of Trainees Required Field**

**Employer Contribution Ratio = Line 11, Column D divided by Line 11, Column C Required Field**

\*Note: Businesses will be required to provide a minimum of 50% of the requested direct training costs; i.e., instructors' wages, curriculum development and manuals/textbooks (some exceptions may apply). Other examples of employer contribution *in addition to the direct costs* may include expenses associated with additional instruction/tuition, curriculum development, manuals/textbooks, the use of space and equipment during the training project and trainee wages (including benefits) of employees during training.

**SECTION 5. Anticipated Outcomes of the Training Project Required**

This section is extremely important and is factored in for a grant approval.

Please check the boxes that apply to the anticipated outcomes of the proposed training project **AND** indicate the estimated number of jobs/employees impacted. **Attach a brief statement to this application for each checked box explaining “how” and/or “why” this training would result in the specific outcome.**

|   |  |
|---|--|
| <input type="checkbox"/> Will create _____ new jobs within our company  | <input type="checkbox"/> Will improve the short-term wage levels of trainees           |
| <input type="checkbox"/> Will create _____ openings in entry-level positions  | <input type="checkbox"/> Will improve the long-term wage levels of trainees            |
| <input type="checkbox"/> Will save _____ jobs within our company  | <input type="checkbox"/> Critical to the long-term viability of our company            |
| <input type="checkbox"/> Will lower employee turnover at our company and retain _____ jobs, as a result                 | <input type="checkbox"/> Will make this location more competitive within company       |
| <input type="checkbox"/> Will promote _____ employees within our company  | <input type="checkbox"/> Would help prevent company from having to relocate operations |
| <input type="checkbox"/> Will enable _____ employees to receive certifications or credentials                           | <input type="checkbox"/> Will make this location more competitive within company       |
| <input type="checkbox"/> Will increase the efficiency of our company  | <input type="checkbox"/> Will assist in the training of veterans                       |
| <input type="checkbox"/> Will enable our company to gain more business  | <input type="checkbox"/> Will assist in the training of minorities                     |
| <input type="checkbox"/> Will increase the profitability of our company   | <input type="checkbox"/> Important to the stated mission of our company                |
| <input type="checkbox"/> Will be an important component of our company’s overall workforce employee development efforts |  |
| <input type="checkbox"/> Will assist in the improvement of international trade opportunities                            |  |

**SECTION 6. Certification by Authorized Company Representative**

**NOTICE OF CONFIDENTIALITY OF INFORMATION**

To the extent feasible and permissible by law, CareerSource Florida (CSF) will honor an applicant’s request that confidential information submitted to CSF will remain confidential. CSF will treat the information confidential only if: (i) the information is in fact protected confidential information such as trade secrets or privileged or confidential commercial or financial information, (ii) the information is specifically marked and identified as confidential by the applicant, (iii) the information is segregated and placed in a separate appendix to the application, and (iv) no disclosure of the information is required by law or judicial order. If the application results in a grant, the honoring of the confidentiality of identified data shall not limit CSF’s right to disclose the details and results of this award to the public.

**MANAGEMENT CERTIFICATION**

I hereby certify that I have read the foregoing application and that the information contained herein is true and accurate to the best of my knowledge and belief. Furthermore, to the best of my knowledge and belief, our company and/or organization does not have any outstanding liabilities to the State of Florida. 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 training award approved through this program.

**TERMS, CONDITIONS & ASSURANCES CERTIFICATION**

I hereby certify that I have read the terms, conditions and assurances posted on the CareerSource Florida web site, and if awarded an Incumbent Worker Training Grant, I certify and hereby agree that our company and/or organization will abide by them for the term of the grant period.

[Note: The individual signing the application below must have authority to enter into contracts on behalf of the applying company.]

|                 |        |
|-----------------|--------|
| Signature:      | Title: |
| E-mail Address: |        |
| Phone:          | Ext:   |
| Print Name:     | Date:  |

**PLEASE ALLOW AT LEAST 45 BUSINESS DAYS FOR YOUR APPLICATION TO BE PROCESSED.**

Mail original and 3 copies to:  
Incumbent Worker Training Program  
Attn: Carmen Mims  
CareerSource Florida  
1580 Waldo Palmer Lane, Suite 1  
Tallahassee, Florida 32308

|  |
|--|
| How did you learn about the Florida Incumbent Worker Training Program? |
|--|

APPLICATION PREPARED BY: (if different than authorized company representative, above)

|                 |        |          |
|-----------------|--------|----------|
| Name:           | Title: | Company: |
| E-mail Address: |        | Phone:   |
| Address:        |        |          |

## Equal Opportunity Assurance Statement

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As a condition of the proposal for this grant, the Applicant assures that it will comply fully with the nondiscrimination and equal opportunity provisions of the following laws:

1. Section 188 of the Workforce Investment Act of 1998 (WIA) which prohibits discrimination against all individuals in the United States on the basis of race, color, religion, sex, national origin, age, disability, political affiliation, or belief, and against beneficiaries on the basis of either citizenship/status as a lawfully admitted immigrant authorized to work in the United States or participation in any WIA Title I B financially assisted program or activity;
2. Title VI of the Civil Rights Act of 1964, as amended, which prohibits discrimination on the basis of race, color, and national origin;
3. Section 504 of the Rehabilitation Act of 1973, as amended, which prohibits discrimination against qualified individuals with disabilities;
4. The Age Discrimination Act of 1975, as amended, which prohibits discrimination on the basis of age; and
5. Title IX of the Education Amendments of 1972, as amended, which prohibits discrimination on the basis of sex in educational programs.

The Applicant also assures that it will comply with 29 C.F.R. Part 37 and all other regulations implementing the laws listed above. This assurance applies to the grant applicant's operation of the WIA Title I – financially assisted program or activity, and to all agreements the grant applicant makes to carry out the WIA Title I – financially assisted program or activity. The Contractor understands that CSF and the United States has the right to seek judicial enforcement of the assurance.

By signing below, the Applicant certifies and assures that it will fully comply with the applicable assurances outlined above.

\_\_\_\_\_  
Name and Title of Authorized Representative

\_\_\_\_\_  
Applicant

\_\_\_\_\_  
Date

**Note: This form MUST be signed and submitted with your application.**