Missouri Department of Economic Development
Missouri Division of Workforce Development

SkillUP Request for Training

☐ INITIAL
☐ AMENDED
☐ TERMINATION

EXPLANATION FOR AMENDMENT

☐ ABAWD
☐ VOLUNTEER

TRAINEE INFORMATION

TRAINEE'S NAME *(Last, First, Middle)*	STATE ID	**Last 4 SSN and DCN** *(Required)*

TRAINEE'S STREET ADDRESS	CITY	STATE	ZIP CODE

I authorize the {training facility name} _____ to release information or records about my training program, financial aid, grades, and billing to the Missouri Division of Workforce Development (DWD) / Missouri Job Center(s)

X _____ _____
TRAINEE'S SIGNATURE DATE

INDIVIDUAL CERTIFICATION AND TRAINING AGREEMENT

(This portion is to be completed by the training facility)

TRAINING FACILITY NAME *(As listed on the Eligibility Training Provider System - ETPS)*

TRAINING FACILITY'S STREET ADDRESS	CITY	STATE	ZIP CODE

TITLE OF TRAINING COURSE *(Attach course/curriculum information describing training.)*

PURPOSE(S) OF TRAINING:
☐ Remediation Training ☐ Prerequisite Training ☐ Skills Training

CREDENTIAL
☐ Certificate
☐ Associate's Degree
☐ Bachelor's Degree

TRAINING BEGINNING DATE

TRAINING ENDING DATE

DAILY CLASS SCHEDULE (Use alpha to match training time to training days)
MON ____ TUES ____ WED ____ THU ____ FRI ____ SAT ____
a) FROM ____ TO ____ • **b)** FROM ____ TO ____ • **c)** FROM ____ TO ____

☐ Part-time Student ☐ Full-time Student ☐ Online *(If any portion of this training will be attended online, please mark this field.)*

NUMBER HOURS PER WEEK	TOTAL INSTRUCTION HOURS	# OF WEEKS

COST OF PROPOSED TRAINING *(As listed on ETPS)*
a. Tuition $_____
b. Fees* $_____
c. Books & Expendable Supplies* $_____
d. OTHER (Must be itemized* at the right; tools, equipment, uniforms, etc.) $_____
e. Total $ _____

Itemize costs of fees, supplies, other items here *(Or attach details)*

**(Itemize costs, fees, supplies, other items if NOT inluded in tuition costs as shown on ETPS)*

HOLIDAY AND VACATION SCHEDULE

(Please list or attach any anticipated holidays scheduled during the student's training program.)

TRAINING FACILITY'S BILLING PLAN
☐ Monthly ☐ Quarterly ☐ Semester ☐ Other: _____

The undersigned, representing the training facility (entered in the Training Facility Name Field above), agrees to provide training for the above-named individual as provided in this agreement with the Missouri Division of Workforce Development (DWD) as authorized under the SkillUP program and for the amount set forth above. Tools and equipment purchased for the trainee remain the property of DWD until the successful completion of training. Changes to the above training plan must be approved in advance by DWD.

_____ X _____ _____
DATE TRAINING FACILITY REPRESENTATIVE'S SIGNATURE TELEPHONE NUMBER

The Missouri Division of Workforce Development (DWD) has referred the above-named individual for training as specified above. DWD agrees the cost of the proposed training (as itemized in the Cost of Proposed Training fields above), and funds have been made available under the SkillUP program, or a combination of funding sources designated in the "Training Justification and Request for Obligation of Funds" portion of this form. Payments will be made to the training facility for training completed upon request by invoice from the facility but not more frequently than on a monthly basis. All payments are subject to availability of funds and applicable provisions of the Act.

_____ X _____ _____
JOB CENTER NAME **AND** CODE NUMBER JOB CENTER REPRESENTATIVE'S SIGNATURE DATE

TRAINEE'S NAME *(Last, First, Middle)*

Last 4 SSN and DCN *(Required)*

FUNDING SOURCES

	FUNDING AMOUNT ($)	EFFECTIVE DATE	SEMESTER DATES FROM — TO
SkillUP Funds			•
PELL Grant			•
WIOA			•
MO Access			•
Other Government			•
Private			•

I certify that I am not required to reimburse any portion of training c costs to any other funding source from either SkillUP funds provided, wages paid under such training, or from my personal funds or income. I also understand and agree that the Missouri Division of Workforce Development (DWD) shall not be required to pay the portion of the cost of training that I have reason to believe will be paid from other approved source(s) as documented.

X _____ _____

TRAINEE'S SIGNATURE DATE

TRANSPORTATION

NUMBER OF MILES FROM TRAINEE'S REGULAR PLACE OF RESIDENCE TO TRAINING FACILITY (WHOLE NUMBER OF MILES) ☐☐☐☐

DATE TRAINING BEGINS

☐

(Subject to the availability of funds)

YOU ARE ENTITLED TO TRANSPORTATION ALLOWANCE AT THE RATE OF $ _____ ONE-WAY COST, BEGINNING _____

TRE	WRE
☐ YES	☐ YES
☐ NO	☐ NO
☐ NOT AVAILABLE	☐ NOT AVAILABLE

TRAINING DATES

SKILLUP FUND OBLIGATION DATE

Enter the actual number of weeks the trainee will attend training. (If the trainee attends training one day of any week, it must be counted toward maximum training weeks.) _____

LIST ANY PERIODS OF PART-TIME ATTENDANCE *(Or attach details)*

Enter the EXACT dates of ALL breaks in training:

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

FROM _____ THROUGH _____ ☐ PAYABLE ☐ NOT PAYABLE

HOLIDAYS *(Or attach details)*

AGENCY DETERMINATION

Your request for ☐ **Training** ☐ **Transportation** has been **SUBMITTED FOR APPROVAL** under the SkillUP program as outlined herein and agreed upon by the Division of Workforce Development (DWD) and the associated training facility. *(Pending the availability of funds)*

OR Your request for ☐ **Training Course Approval** ☐ **Training-related Costs** ☐ **Transportation** is **DENIED** for the following reason:

JOB CENTER NAME **AND** CODE NUMBER

X _____ _____

JOB CENTER REPRESENTATIVE'S SIGNATURE DATE

FOR DWD PROGRAM OPERATOR USE ONLY

ACCOUNT

APPROVED ☐ **DENIED** ☐

X _____ _____

PROGRAM OPERATOR APPROVING AUTHORITY SIGNATURE DATE

TRAINEE'S NAME *(Last, First, Middle)*	**Last 4 SSN and DCN** *(Required)*

TRAINEE TERMINATION REPORT

(This portion is to be completed by the training facility)

This portion of the form is to be completed by the training facility immediately following the trainee's termination of training. If the trainee attends multiple components of training (remedial, prerequisite, and/or skills training) at your facility, it may be necessary to submit a copy of this form's "Trainee Termination Report" for each component. Please return the completed "Trainee Termination Report" to the Missouri Job Center noted on the form.

ACTUAL TRAINING

Actual Start Date _____ Actual End Date _____

NATURE OF TERMINATION

☐ Completed Course – Achieved Training Objective ☐ Did Not Achieve Training Objective ☐ Never Started Training

REASON FOR TERMINATION IF TRAINING OBJECTIVE WAS NOT ACHIEVED

TRAINING FACILITY NAME *(As listed on ETPS)*

LOCATION

EMPLOYMENT STATUS AT TIME OF TERMINATION

☐ Employment found in training-related field

☐ Employment found in non-training-related field

☐ Unemployed – looking for work

☐ Other *(Explain:)*

☐ Remedial termination only; scheduled to attend skills training

NAME AND ADDRESS OF EMPLOYER, IF KNOWN

STARTING WAGE, IF KNOWN

$ _____ (Amount) per _____ (Frequency)

NAME AND TITLE OF TRAINING FACILITY REPRESENTATIVE

X _____ TRAINING FACILITY REPRESENTATIVE'S SIGNATURE _____ DATE

FOR JOB CENTER STAFF USE ONLY – ATTN: SKILLUP REPS

JOB CENTER NAME **AND** CODE NUMBER

X _____ JOB CENTER REPRESENTATIVE'S SIGNATURE _____ DATE

ACTUAL NUMBER OF WEEKS ATTENDED

☐ Justifiable Cause ☐ Prerequisite Only

☐ Non-Justifiable Cause ☐ Skills Training Only

☐ Remedial Only

SKILLUP FUND OBLIGATION BALANCE

RETURN TRAINEE TERMINATION REPORT TO:

MISSOURI JOB CENTER

_____

_____

_____

ATTN: _____

For additional information about Missouri Division of Workforce Development services, contact a Missouri Job Center near you. Locations and additional information are available at jobs.mo.gov or (888) 728-JOBS (5627).

Missouri Division of Workforce Development is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Missouri Relay Services are available at 711.