Missouri Department of Higher Education and Workforce Development
Office of Workforce Development
Supportive Services Determination of Need

Date of Request:

Name *(Last, First, Middle)*

Grant:

State ID:

SUPPORTIVE SERVICE REQUESTED

(SELECT SUPPORTIVE SERVICE(S) REQUESTED, INCLUDE A BRIEF DESCRIPTION AND DOLLAR AMOUNT ASSOCIATED)

☐ **Housing** **$**_____

☐ **Transportation/Gas** **$**_____

☐ **Child care** **$**_____

☐ **Other:** **$**_____

☐ **Medical Services** **$**_____

DETERMINATION OF NEED

How is the need a barrier to employment or training?

What is likely to happen if OWD does not provide this assistance?

Are there special circumstances that should be considered?

What is the plan for sustainability following OWD's assistance?

Has the participant met their maximum available to them?

Does OWD have the funding available to provide this assistance?

Participant Signature

Date:

Workforce Development Specialist Signature

Date:

TO BE COMPLETED BY GRANT COORDINATOR

☐ **Approved**

Date Request is Approved Through:

☐ **Denied**

Reasons:

Grant Coordinator Signature

Date: