



Missouri Department of Economic Development
Missouri Division of Workforce Development
SkillUP Request for Training

- INITIAL
- AMENDED
- TERMINATION



EXPLANATION FOR AMENDMENT

TRAINEE INFORMATION

TRAINEE'S NAME (Last, First, Middle)		APID	DCN	
TRAINEE'S STREET ADDRESS		CITY	STATE	ZIP CODE
I authorize the {training facility name} _____ to release information or records about my training program and grades 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				
TRAINING FACILITY'S STREET ADDRESS		CITY	STATE	ZIP CODE
TITLE OF TRAINING COURSE <i>(Attach course/curriculum information describing training.)</i>		PURPOSE(S) OF TRAINING: <input type="checkbox"/> Remediation Training <input type="checkbox"/> Prerequisite Training <input type="checkbox"/> Skills Training		
ASSOCIATE'S DEGREE <input type="checkbox"/> <i>(If training will lead to an Associate's Degree, please mark this field.)</i>	TRAINING BEGINNING DATE	TRAINING ENDING DATE	DAILY CLASS SCHEDULE FROM _____ TO _____	
<input type="checkbox"/> Part-time Student <input type="checkbox"/> Full-time Student <input type="checkbox"/> Online <i>(If any portion of this training will be attended online, please mark this field.)</i>		NUMBER HOURS PER WEEK	TOTAL INSTRUCTION HOURS	# OF WEEKS
COST OF PROPOSED TRAINING		Itemize OTHER costs here:		
a. Tuition & Fees	\$ _____	}		
b. Books & Expendable Supplies	\$ _____			
c. OTHER (Must be itemized at the right; tools, equipment, uniforms, etc.)	\$ _____			
d. Total	\$ _____			
HOLIDAY AND VACATION SCHEDULE				
<i>(Please list or attach any anticipated holidays scheduled during the student's training program.)</i>				
TRAINING FACILITY'S BILLING PLAN				
<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semester <input type="checkbox"/> 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	_____ X _____ TRAINING FACILITY REPRESENTATIVE'S SIGNATURE			_____ X _____ 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	_____ X _____ JOB CENTER REPRESENTATIVE'S SIGNATURE			_____ X _____ DATE

TRAINEE'S NAME (Last, First, Middle)

FUNDING SOURCES

	<u>FUNDING AMOUNT (\$)</u>	<u>EFFECTIVE DATE</u>
SkillUP Funds	_____	_____
PELL Grant	_____	_____
WIOA	_____	_____
Other Government	_____	_____
Private	_____	_____

I certify that I am not required to reimburse any portion of training 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)

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DATE TRAINING BEGINS

(Subject to the availability of funds)

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

TRAINING DATES

METP 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

Enter the EXACT dates of ALL breaks in training:

FROM _____ THROUGH _____ PAYABLE NOT PAYABLE

HOLIDAYS

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)*

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

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

FOR DWD CENTRAL OFFICE USE ONLY

ACCOUNT

APPROVED DENIED

X _____
CENTRAL OFFICE SIGNATURE DATE

TRAINEE'S NAME (Last, First, Middle)

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

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

\$ _____ per _____
(Amount) (Frequency)

NAME AND TITLE OF TRAINING FACILITY REPRESENTATIVE

X _____
TRAINING FACILITY REPRESENTATIVE'S SIGNATURE DATE

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

FOR JOB CENTER USE ONLY – ATTN: SKILLUP REPS

DWD CENTRAL OFFICE USE ONLY

ACTUAL NUMBER OF WEEKS ATTENDED

- Justifiable Cause Prerequisite Only
- Non-Justifiable Cause Skills Training Only
- Remedial Only

METP FUND OBLIGATION BALANCE

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 TTY Users can call (800) 735-2966 or dial 7-1-1.