

GLOW TRAINING FOR ADULT AND DLW FUNDS APPROVAL FORM
Must be submitted prior to Training to GLOW WDB Director Tracy.VanVleck@geneseeny.gov

INDIVIDUAL TRAINING ACCOUNT

Service Provider Name: _____ Date: _____
Customer's Last Name, First Initial: _____, _____ OSOS ID#: _____
Type of ITA: _____ Training Start Date: _____ End Date: _____
Name of Training Provider: _____
Are they listed on the NYS Eligibility Training Provider List? _____ Yes _____ No
Amount and Type of Funding: _____ Subsequent Years? _____
Summary of Situation: _____

ON-THE-JOB TRAINING/CUSTOMIZED TRAINING/TRANSITIONAL JOBS WE

Service Provider Name: _____ Date: _____
Customer's(s) Last Name, First Initial: _____, _____ OSOS ID#: _____
OJT/CT/Transitional Jobs Employer Worksite: _____ Training Start Date: _____ End Date: _____
Estimated Amount and Type of Funding for OJT/CT/Transitional Jobs: _____
Summary of Situation: _____

SUPPORTIVE SERVICES

Service Provider Name: _____ Date: _____
Customer's Last Name, First Initial: _____, _____ OSOS ID#: _____
Type of Supportive Services: _____
Estimated Amount and Type of Funding for Supportive Services: _____
Is staff aware of any other free resources available to help the customer with these needs? _____ Yes or _____ No
Summary of Situation: _____

Service Provider Signature _____ Date: _____

Approval by WDB Executive Director

Name: Tracy VanVleck _____ Date: _____

Signature: _____

7/22/120/C: Kristine Langless, GR