

GLOW TRAINING FOR TICKET TO WORK REVENUE FUNDS APPROVAL FORM

Must be submitted prior to Training to GLOW WDB Director jlazarony@co.genesee.ny.us

INDIVIDUAL TRAINING ACCOUNT

Service Provider Name: _____ Date: _____
Customer's Last Name, First Initial: _____, _____ OSOS ID#: _____
Type of ITA: _____ Training Start Date: _____ End Date: _____
What is the type of eligible documentation that was provided for the disability: _____
Name of Training Provider: _____
Are they listed on the NYS Eligibility Training Provider List? _____ Yes _____ No
Amount and Type of Funding: _____
Summary of Situation: _____

ON-THE-JOB TRAINING OR WORK EXPERIENCE

Service Provider Name: _____ Date: _____
Customer's(s) Last Name, First Initial: _____, _____ OSOS ID#: _____
What is the type of eligible documentation that was provided for the disability: _____
Employer Worksite: _____ Training Start Date: _____ End Date: _____
Estimated Amount and Type of Funding for OJT/WE: _____
Summary of Situation: _____

SUPPORTIVE SERVICES

Service Provider Name: _____ Date: _____
Customer's Last Name, First Initial: _____, _____ OSOS ID#: _____
What is the type of eligible documentation that was provided for the disability: _____
Type of Supportive Services: _____
Estimated Amount and Type of Funding for Supportive Services: _____
Summary of Situation: _____

Service Provider Signature _____ Date: _____

Approval by WDB Executive Director

Name: Jay Lazarony Date: _____

Signature: _____

C: Kristine Langless, GR

8/10/18