

Coordination of Training Funds

Training Provider: _____

Training Provider Contact Person Name and Phone Number: _____

Training Provider Address: _____

Training Program: _____ O*Net Code: _____

Length of Training Program: _____ Projected Training Completion Date: _____

Current: Semester/Quarter Start Date: _____ Semester/Quarter End Date: _____

Course Number	Course Title	Hours

Participant Name: _____ Student ID Number: _____

I am enrolled in the above listed classes and hereby authorize the exchange of information between the Employment Specialist and the Financial Aid Office at the above named school regarding the awarding of any financial aid from any source.

Participant Signature: _____ Date: _____

Please return the completed form to:

South Central Workforce Investment Board, attention: _____

COST OF ATTENDANCE (This Semester)

STUDENT'S FINANCIAL AID (This Semester)

Tuition	\$ _____	PELL Grant Disbursement	\$ _____
Supplies	\$ _____	___ was <u>not</u> eligible due to income	___ was <u>not</u> eligible due to default
Books (include rental fees & attach a list of required books)	\$ _____	___ Training Provider is <u>not</u> PELL eligible	
Tools	\$ _____	MO Access	\$ _____
Uniforms	\$ _____	UMOS	\$ _____
Other (Please specify)	\$ _____	Tuition Waiver	\$ _____
	\$ _____	Vocational Rehabilitation	\$ _____
Fees (Please specify)	\$ _____	Scholarship(s)	\$ _____
	\$ _____	VA/Military	\$ _____
	\$ _____	Other (Please do not include loans)	\$ _____

By signing below, the financial aid officer (or those personnel who perform those duties) agrees to inform the South Central Workforce Investment Board, of the amount and disposition of financial aid to each participant awarded after enrollment of the participant, as part of continuing, regular information sharing process

Financial Aid Officer's Signature: _____ Date: _____

Instructions for Completing the Coordination of Training Funds

This form is to be completed each semester or term of training.

Employment Specialist complete the top section.

Training Provider: Where is the participant attending training

Training Provider Contact Person Name and Phone Number: Who is responsible at the training provider for student financial aid

Training Provider Address: Mailing address of the contact person

Training Program: What specific program of training will the SCWIB provide assistance for

Length of Training Program: Be specific, number of years, months or weeks

Projected Training Completion Date: If the participant follows the school curriculum, put the date they should complete the training

Current: Semester/Quarter Start Date: What day will the participant start class/training for this semester

Semester/Quarter End Date: What day will the participant finish class/training for this semester

Table

Course Number: List the school's course identification number in which the student is enrolled

Course Title: List the school's title of the course the participant is enrolled in

Hours: List the credit hours of the course the participant is enrolled in

Participant Name: Print or Type the name of the participant

Student ID Number: Participant will need to provide the ID number that identifies them at the school

Participant Signature: Participant must sign this form before it is sent to the school

Date: The participant will need to date the day the form is signed

Add the name of the staff person working with the participant.

The remainder of the form will need to be completed by the school financial aid office and returned to the SCWIB before staff can complete the ITA