**GLOW TRAINING FOR ADULT AND DLW 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:

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: Jay Lazarony Date:

Signature:

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