

CUSTOMIZED TECHNICAL ASSISTANCE APPLICATION

(* = required field)

I. CONTACT INFORMATION

*First Name	
Middle Initial	
*Last Name	
*Your Title	
*Organization Name	
*Street Address	
*City	
*State	
*ZIP Code	
*Phone Number	
Fax Number	
*Email Address	
Website Address	

II. ORGANIZATION INFORMATION

***A. Check the type of organization. Select all that apply.**

- | | |
|--|---|
| <input type="checkbox"/> Community-Based/Grassroots | <input type="checkbox"/> Health Services |
| <input type="checkbox"/> Criminal Justice Agency | <input type="checkbox"/> Medical Health Care |
| <input type="checkbox"/> Law Enforcement* | <input type="checkbox"/> Mental Health Care |
| <input type="checkbox"/> Prosecution* | <input type="checkbox"/> Human/Social Services |
| <input type="checkbox"/> Court* | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Corrections* | <input type="checkbox"/> Legislation/Policymaking |
| <input type="checkbox"/> Juvenile Justice System | <input type="checkbox"/> Military* |
| <input type="checkbox"/> Federal Criminal Justice System | <input type="checkbox"/> Research |
| <input type="checkbox"/> Tribal Justice System | <input type="checkbox"/> Rural Victim Services |
| <input type="checkbox"/> Education | <input type="checkbox"/> Urban Victim Services |
| <input type="checkbox"/> Schools: K-12 | <input type="checkbox"/> VOCA Assistance |
| <input type="checkbox"/> University/College Campus* | <input type="checkbox"/> VOCA Compensation |
| <input type="checkbox"/> Faith-Based Organization | <input type="checkbox"/> Other: |

*These organizations or their victim services programs are eligible to apply, as long as the requested assistance improves their services to crime victims.

***B. Check the type of services your organization offers. Select all that apply.**

- | | |
|--|--|
| <input type="checkbox"/> Advocacy – General | <input type="checkbox"/> Information/Referral |
| <input type="checkbox"/> Case Management | <input type="checkbox"/> Legal Advocacy |
| <input type="checkbox"/> Child Care | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Compensation/Restitution | <input type="checkbox"/> Medical Assistance |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Dental Assistance |
| <input type="checkbox"/> Group Treatment/Support Group | <input type="checkbox"/> Monitoring Subgrantees |
| <input type="checkbox"/> Crisis Intervention | <input type="checkbox"/> Notification |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Shelter |
| <input type="checkbox"/> Response | <input type="checkbox"/> Safe House |
| <input type="checkbox"/> Mental Health Counseling | <input type="checkbox"/> Transitional Housing |
| <input type="checkbox"/> Criminal Justice System | <input type="checkbox"/> Technical Assistance |
| <input type="checkbox"/> Advocacy/Assistance | <input type="checkbox"/> Training |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Food/Clothing Assistance | <input type="checkbox"/> Victim/Offender Mediation |
| <input type="checkbox"/> 24-Hour Hotline | <input type="checkbox"/> Other Direct Services: |

***C. Is your organization an OVC grantee? YES NO**

If YES, please indicate the name of the organization’s OVC grant monitor:

If YES, please indicate the amount of OVC funding the organization has received in the last 12 months:

OVC TTAC will contact the grant monitor listed regarding your request.

Do you receive VOCA funding from your state? YES NO

***D. Has your organization previously received OVC TTAC assistance? YES NO**

If YES, when did you receive assistance most recently?

What was the type of assistance and purpose of the assistance provided?

III. REQUEST INFORMATION

Please answer the questions below for the assistance you are requesting.

***A. Check the primary victimization/crime issues your organization or community needs to address.**

- | | |
|--|---|
| <input type="checkbox"/> Assault | <input type="checkbox"/> Gun Violence |
| <input type="checkbox"/> Abduction/Kidnapping | <input type="checkbox"/> Hate/Bias Crime |
| <input type="checkbox"/> Bullying | <input type="checkbox"/> Identity Theft/Fraud/Financial Crime |
| <input type="checkbox"/> Campus Crime/School Violence | <input type="checkbox"/> Labor Trafficking |
| <input type="checkbox"/> Child Abuse | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Children Exposed to Violence | <input type="checkbox"/> SANE/SART |
| <input type="checkbox"/> Computer/Internet/Cyber Crime | <input type="checkbox"/> Sex Trafficking |
| <input type="checkbox"/> Dating Violence | <input type="checkbox"/> Sexual Abuse/Violence |
| <input type="checkbox"/> Domestic and Family Violence | <input type="checkbox"/> Terrorism and Mass Violence |
| <input type="checkbox"/> DWI/DUI | <input type="checkbox"/> Other: |
| <input type="checkbox"/> Elder Abuse | |

B. Provide information on the request in the chart below.

*Describe the problem that needs to be addressed.	
*How will this assistance help address the problem and improve	

services to crime victims in the short and long term?	
*Have you have received assistance on this issue before? If so, when and from whom?	
*Please list any local/regional programs or individuals who are partnering with you on this request.	
*What is your preferred timeframe to receive this assistance?	mm/dd/yyyy – mm/dd/yyyy
*Does this assistance need to be delivered in concert with any scheduled events? If yes, please note those dates.	mm/dd/yyyy – mm/dd/yyyy
*Name of event/training, location of event/training, and name of facility.	Name: _____ Address: _____ _____ City: _____ State: _____ Zip Code: _____ Facility: _____
*Provide the start and end time for the event.	hh:mm – hh:mm
Provide the title of the workshop.	
Provide a description of the workshop.	
Provide the start and end time for the workshop.	hh:mm – hh:mm
*Please provide at least three learning objectives. For assistance on writing learning objectives, please visit OVC TTAC's How to Develop Learning Objectives at: https://www.ovcttac.gov/downloads/docs/howWeCanHelp/Writing_508c_033116_DM.pdf .	
*How many people do you expect to participate?	
*List any other information that you would like us to know.	

***C. Who will receive the assistance described above? Select all that apply.**

- | | |
|--|--|
| <input type="checkbox"/> Administrators | <input type="checkbox"/> Law Enforcement Personnel |
| <input type="checkbox"/> Attorneys | |
| <input type="checkbox"/> Consultants | <input type="checkbox"/> Legislators |
| <input type="checkbox"/> Corrections Personnel | <input type="checkbox"/> Mental Health Providers |
| <input type="checkbox"/> Court Personnel | <input type="checkbox"/> Probation Personnel |
| <input type="checkbox"/> Educators | <input type="checkbox"/> Prosecutors |
| <input type="checkbox"/> Emergency Service Providers | <input type="checkbox"/> Tribal Service Providers |
| <input type="checkbox"/> Faith-Based Service Providers | <input type="checkbox"/> Victim Advocates |
| <input type="checkbox"/> General Public | <input type="checkbox"/> Volunteers |
| <input type="checkbox"/> Health Care Providers | <input type="checkbox"/> Other: <input type="text"/> |
| <input type="checkbox"/> Judges | |

***D. Please indicate the matching support your organization (or partner agencies, if any) will be contributing toward this request.**

- | | |
|--------------------------|--------------------------|
| Consultant Airfare | <input type="checkbox"/> |
| Consultant Meals | <input type="checkbox"/> |
| Consultant Lodging | <input type="checkbox"/> |
| Consultant Ground Travel | <input type="checkbox"/> |

Please verify that your organization is able to provide the following:

- | | |
|--|--------------------------|
| Marketing/Outreach Materials | <input type="checkbox"/> |
| Reproduction of Consultant's Materials | <input type="checkbox"/> |
| Audiovisual Equipment for Consultant's Session | <input type="checkbox"/> |
| Facility Costs | <input type="checkbox"/> |

IV. STATEMENT OF UNDERSTANDING

By submitting this application to OVC TTAC, I understand that upon approval of this application for technical assistance, I agree to keep OVC TTAC informed of any circumstances that may impact the delivery of the technical assistance, including changes in the date of the event, event cancellation, or difficulties communicating with the assigned consultant.