

SPEAKER SUPPORT 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 offered by your organization. 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 Advocacy/Assistance | <input type="checkbox"/> Technical Assistance |
| <input type="checkbox"/> Financial Assistance | <input type="checkbox"/> Training |
| <input type="checkbox"/> Food/Clothing Assistance | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> 24-Hour Hotline | <input type="checkbox"/> Victim/Offender Mediation |
| | <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 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 received OVC TTAC assistance previously? YES NO**

If YES, when did you receive assistance most recently? mm/dd/yyyy

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.

*What is your preferred timeframe to receive this assistance?	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

<p>*Please provide at least three learning objectives.</p> <p>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.</p>	
<p>*How many people do you expect to participate?</p>	

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.