

TRAINING 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 | <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 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?

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
*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 |

- Faith-Based Service Providers
- General Public
- Health Care Providers
- Judges

- Victim Advocates
- Volunteers
- Other:

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

- Consultant Airfare
- Consultant Meals
- Consultant Lodging
- Consultant Ground Travel

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

- Marketing/Outreach Materials
- Reproduction of Consultant's Materials
- Audiovisual Equipment for Consultant's Session
- Facility Costs

IV. TRAINING SPECIFICATIONS

***Please select the training you are requesting.**

Name of the requested training.	
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Please complete the following chart to indicate the support individual or partner organizations (if any) will be contributing toward this request. If more than one, please indicate which partner is providing the selected service. Select all that apply.

Donated	Fee Charged	Goods/Service Provided	Name of Individual/ Partner Organization
<input type="checkbox"/>	<input type="checkbox"/>	Facility Cost	
<input type="checkbox"/>	<input type="checkbox"/>	Audiovisual Equipment	
<input type="checkbox"/>	<input type="checkbox"/>	Marketing and Outreach	
<input type="checkbox"/>	<input type="checkbox"/>	Materials (flipchart, pens, tent cards, highlighters, etc.)	
<input type="checkbox"/>	<input type="checkbox"/>	Refreshments	
<input type="checkbox"/>	<input type="checkbox"/>	In-Kind	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	
<input type="checkbox"/>	<input type="checkbox"/>	Other:	

V. TRAINING SITE REQUIREMENTS

Please check the appropriate boxes to indicate that these facility requirements will be available.

***Registration Desk**

- One rectangular registration table with two chairs
- One wastebasket

***General Session Room (Accessible the evening prior to training for set-up)**

- Tables and chairs to accommodate 30-40 participants (4-6 participants per table)
- One table with one chair in the back of the room for the onsite monitor to use as a resource table
- One head table for two instructors in front of the room
- Two easels with tear sheets and markers
- Two wastebaskets

***Special Training Requirements**

If you are offering the following trainings, please note the breakout rooms that are required.

- DNA in Sexual Assault Cases: The Role of Law Enforcement, SAFE/SANE Nurses, and Victim Advocates* — two breakout rooms
- The Ultimate Trainer* — one breakout room
- Not applicable

***Audiovisual Needs (for the General Session Room)**

- One projection screen
- One LCD projector on cart or table
- One laptop — must have Microsoft PowerPoint 2007, as well as the capability to play CDs and DVDs
- External speaker(s)

***Business Services**

- Onsite copying services are required at trainings that offer Continuing Education Units (CEUs).
- Not applicable

VI. FACILITY – GENERAL INFORMATION

<p>*Do the number, type, and size of the meeting rooms meet training meeting space requirements described previously?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain:</p>
<p>*The facility must be compliant with the Americans with Disabilities Act requirements. Is it?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what are the issues?</p>

<p>*Is the shipping address the same as the facility street address?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, where should the packages be directed?</p> <p>First Name: _____</p> <p>Last Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____</p> <p>ZIP Code: _____</p>
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VII. TRAINING REGISTRATION AREA

<p>*Is there a special area set aside for registration?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>*The registration area must be wheelchair accessible. Is it?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what are the issues?</p>
<p>*Do you have a staff member or volunteer to assist with registration?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

VIII. MEETING SPACE

<p>*What is the training room maximum occupancy?</p>	
<p>*Are breakout rooms available?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, how many and what size?</p>
<p>*Are walls soundproof?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>*Are there temperature controls in room(s)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>*Is the quality of the lighting very good or excellent?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what are the issues?</p>

<p>*Is the sound system very good or excellent?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, what are the issues?</p>
<p>*Are there any obstructions to seeing or hearing the instructors (e.g., columns, corners, near the lobby)?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what are the issues?</p>
<p>*Are the A/V services onsite?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, who will provide A/V services?</p> <p>Company Name: _____</p> <p>Contact Person: _____</p> <p>Email Address: _____</p> <p>Phone Number: _____</p>
<p>*Are copying/duplicating services available?</p> <p><i>Please note: Onsite copying services are a requirement of trainings providing Continuing Education Units (CEUs).</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, what is the turnaround time for services (in hours)?</p> <p>If yes, what are the charges for this service?</p>
<p>*Are men's and women's restrooms conveniently located?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>

IX. LODGING

<p>*Is the training site at a hotel at which instructors, onsite coordinators, and out-of-town participants are able to stay?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please provide the name and address of the hotel where instructors, onsite coordinators, and out-of-town participants will stay.</p> <p>Name: _____</p> <p>Address: _____</p> <p>City: _____</p> <p>State: _____</p> <p>ZIP Code: _____</p> <p>How far away is it from the training site?</p>
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	What transportation options are available to and from the training site?
*Will the recommended hotel likely sell out during the training dates?	<input type="checkbox"/> Yes <input type="checkbox"/> No

X. STATEMENT OF UNDERSTANDING

This section ensures that you attest to and confirm agreement with program criteria and guidelines. You must agree/certify that your organization meets the requirements of the items listed above in order to be considered for OVC's approval.

I certify that (1) my organization has the experience and capacity to host a training, (2) the information provided in this application is accurate and verifiable, (3) my organization supports the event.

I understand and agree that any false information, misrepresentation, or willful or negligent failure to disclose any information pertinent to this application or my organization will constitute sufficient grounds for the removal of my application from consideration, the return of funding by my organization to OVC if funding has been granted, and/or the inability of my organization to apply for future funding opportunities.

Signature of Organization's Chief Executive Title Date

Name of Organization