

## A. DELEGATE AGENCY Title I Provider Checklist

Respondent Name: \_\_\_\_\_

Proposed Program Location: \_\_\_\_\_

Proposed Geographic Location/Targeted Population: \_\_\_\_\_

Please use the following checklist to confirm all the documents are included in your packet.

### **Program Forms**

- **Organizational Leadership Demographic Survey (Respond through Link)**
- Respondent Information Form
- Memorandum of Understanding (MOU) with partners if applicable
- Executive Summary
- Program Narrative Response (30 pages maximum)
- Job Titles and Descriptions
- Resumes Organized by Job Title
- Proposed Planned Outcomes Form
- Grant Summary Form
- Reference List Form
- Organizational Chart

### **Fiscal Forms**

- Financial Narrative Response
- Budget Summary Forms for each funding source
- Budget Narrative Form
- Fiscal Questionnaire
- Segregation of Duties Form
- IRS W-9 Request for Taxpayer Identification Number and Certifications
- Certificate of Good Standing or Tax Exemption Certificate
- Copy of most recent financial audit
- Cost Allocation Plan
- List of Board Members

## B. Respondent Information Form

Legal Name of Applicant Agency			
Geographic Area and/or Priority Population			
Number of Years in Business			
FEIN Number			
DUNS Number			
Type of Organization	<input type="checkbox"/> Educational Institution <input type="checkbox"/> Minority Business Enterprise <input type="checkbox"/> Female Business Enterprise <input type="checkbox"/> Disadvantaged Business Enterprise <input type="checkbox"/> Private for Profit <input type="checkbox"/> Private Not-for-Profit <input type="checkbox"/> Unit of Government		
Address – Administrative Office	Address		
	City, State ZIP		
	Web Site URL		
Address of Primary Service Location – This is the location where the services described in this application will be provided.	Address		
	City, State ZIP		
Answer YES, if applying for Partnership site at 10325 South Halsted Street, Chicago, Illinois			
Principal of Agency – CEO/Executive Director/President	Name		
	Title		
	Email Address		
	Phone		
Programmatic Contact Person	Name		
	Title		
	Email Address		
	Phone		
	<b>Amount Requested</b>	<b>Total Served</b>	<b>Cost Per Served</b>
Adult Funding	\$	#	\$
Dislocated Worker Funding	\$	#	\$
Total Amount Requested	\$	#	\$
Amount of Leverage Funds			
Percentage of Leverage Funds			

### C. Respondent Grant History Form

Please complete the attached Grant History Form for all **Workforce Contracts/Grants received** within the past three years regardless of source. If the nature of the grant does not match the goals and outcomes identified here, please identify and include primary goals and outcomes of the grant.

<b>Organization NAME:</b>	
<b>RESPONDENT GRANT HISTORY FORM</b>	
Identify Funder	
Funding Type	
Award Amount	
Time Period	
Planned Enrollment Goal	
Actual Enrollments	
Planned Placement Goal	
Actual Placements	
Other Benchmarks Planned	
Other Benchmarks Achieved	
Identify Funder	
Funding Type	
Award Amount	
Time Period	
Planned Enrollment Goal	
Actual Enrollments	
Planned Placement Goal	
Actual Placements	
Other Benchmarks Planned	
Other Benchmarks Achieved	
Identify Funder	
Funding Type	
Award Amount	
Time Period	
Planned Enrollment Goal	
Actual Enrollments	
Planned Placement Goal	
Actual Placements	
Other Benchmarks Planned	
Other Benchmarks Achieved	

### D. Respondent References Form

Please identify three references from funders or organizations that can attest to the organization's ability to serve the target communities, priority population and meet benchmarks. Please ensure the accuracy of the contact information and inform references of The Partnership's reference checking process. By identifying a reference, Respondent authorizes the reference to release organizational information and performance data to The Partnership.

<b>Organization NAME:</b>	
<b>REFERENCE LIST INFORMATION</b>	
Reference #1 Organization Name	
Reference #1 Contact Person Name	
Reference #1 Contact Phone Number	
Reference #1 Email Contact	
Reference #1 Nature of Relationship	
Reference #2 Organization Name	
Reference #2 Contact Person Name	
Reference #2 Contact Phone Number	
Reference #2 Email Contact	
Reference #2 Nature of Relationship	
Reference #3 Organization Name	
Reference #3 Contact Person Name	
Reference #3 Contact Phone Number	
Reference #3 Email Contact	
Reference #3 Nature of Relationship	

**E. Planned Outcome Form**

DELEGATE AGENCY Title I PROPOSED PLANNED OUTCOMES		
Organization Name:		
	Proposed Planned Numbers	
Benchmark	Adult	Dislocated Workers
Proposed Number of Served		
Proposed Number of New Enrollments		
Proposed Number of OJTs		
Proposed Number of Placements		
Proposed Number of Business Served		
Proposed Planned Minimum Active Case Level		
Overall Cost Per Served ( <i>Requested amount/total served</i> )		
Overall Cost Per Minimum Active Case Level ( <i>Requested amount/ planned minimum active level</i> )		
Overall Cost Per Placement ( <i>Requested amount/total placed</i> )		