Updated 10/2017

WESTERN ARKANSAS EMPLOYMENT DEVELOPMENT AGENCY

Attachment #2

1500 MAIN ● P.O. BOX 1266 ● VAN BUREN, AR 72957
(479) 474-7061 FAX (479) 471-0827

WIOA INDIVIDUAL TRAINING ACCOUNT (ITA) VOUCHER

Title: Adult Dislocated Worker Youth
(Circle one)

TRAINING INSTITUTION:
Name: _____
Address: _____
_____
Contact Person: _____
Telephone & Fax: _____

PARTICIPANT INFORMATION

NAME: _____ Social Security Number: _____

Address: _____ Telephone: _____

TRAINING

Training program: _____ Start Date: _____ Estimated Completion Date: _____

Upon completion, the enrollee will receive: ( ) Certification ( ) Diploma ( ) Associate ( ) Bachelor ( ) Other_____
The curriculum for this training is identified in: ( ) Course Catalog ( ) Student's Approved Degree Plan **SEE ATTACHED SCHEDULE**

ELIGIBLE TRAINING PROVIDER

FINANCIAL INFORMATION FOR THE _____ SEMESTER (For Financial Aid Officer or designee use)
ESTIMATED COST OF ATTENDANCE, THE SOURCE, AMOUNT, AND DISTRIBUTION OF FINANCIAL AID IS LISTED:

TUITION: _____ CHILD CARE: _____

FEES: _____ TRANSPORTATION: _____

BOOKS: _____ ROOM AND BOARD _____

SUPPLIES: _____ OTHER _____

( ) FINANCIAL AID NOT DETERMINED **( ) AWARD LETTER ATTACHED**
( ) NOT ELIGIBLE FOR FINANCIAL AID & REASON _____
( ) NO PELL GRANT FUNDS WILL BE USED FOR TUITION, FEES OR BOOKS

The undersigned agrees to provide training and certifies that all charges for training are made in accordance with provisions of the training agreement.
ITA may be null and void if invoice is not received by WAEDA within 60 days of current semester start date.

Signature: Title: Date:

AUTHORIZATION FOR WIOA FUNDS – WIOA STAFF COMPLETION

(Any Modification of the following must be made by a WAEDA staff member)

APPROVED AND AUTHORIZED CLASSES LISTED THAT WAEDA WILL BE RESPONSIBLE FOR, UP TO BUT NOT EXCEEDING THE AMOUNTS LISTED BELOW:

_____ _____ _____

_____ _____ _____

Tuition $ _____ Fees $ _____ Books $ _____ Supplies $ _____

Total $ _____

For any changes, mark through the amount, and modify the amount then fill out the bottom line.

The undersigned certifies that the training provider will be reimbursed for the expenditures authorized, provided such charges are consistent with provisions of the training agreement.

Signature: Title: Date: _____

Modified Total (if applicable) $ Changes Made By: Date:

PARTICIPANT

I acknowledge the agreement between WAEDA/WIOA, the Eligible Training Provider and myself. I have been informed of the amount and distribution of financial assistance provided to me. I consent to the release of any information in my records. This information may include (but is not limited to) grades, progress reports, class schedule, financial aid, job placement/employer info, home address, telephone number, and other pertinent information the institution compiles.

Signature: Date: