Funding Request for Professional Development Training

LCJB HealthChoices believes that the building of organizational capacity through staff development is essential to improving quality and effectiveness in its providers' programs, services, and administration. LCJB HC will consider requests from providers for funding to reimburse costs for training opportunities which will expand clinical competencies and have the potential to address the underserved or unmet treatment needs of Lycoming- Clinton HealthChoices members.

Please complete all sections of the request form and **attach a copy of the training announcement or registration form showing dates and costs of the training.**

Requests will be reviewed and providers will be notified of a decision within 30 days of receipt of the completed form.

Provider Name: _____ Date(s) of Training: _____

Contact Person for Request: _____ Telephone:_____

Email address: _____

Contact Person for Invoice:_____ Telephone:_____

Email address: _____

Check should be made payable to:_____

Check should be sent to: _____

Description of Request

Name of Training: _____

Funding Amount Requested:_____

Names/Titles of Participants Attending the Training: _____ _____

_____ _____ _____

1. Describe the population and/or unmet treatment needs identified by your agency that will be addressed as a result of attending this training. Please include any supporting information your agency has collected (from needs assessments, client surveys, outcome studies, etc.) about this population and/or unmet need.

2. How will funding your attendance at this training advance LCJB HealthChoices' goals for addressing priority populations and/or unmet treatment needs? How many HealthChoices members are expected to benefit from your attendance at this training?

3. Provide details about this training and the rationale for your interest in attending (ie training is offered infrequently, no local training opportunities exist, trainer is recognized expert in the field, training is a requirement for certification or license, etc.) List the sessions in which you will be participating.

Training Budget

Using the table below, provide a breakout of costs for the training funds being requested and include funding from your agency, in-kind contributions, and funding obtained from any other funding source.

	Total Cost $	Other Funding Sources $	LCJB HC Funding Request $
Registration Fees			
Travel/Mileage- getting to airport, rental car			
Lodging			
Meals/Incidentals			
Training Materials			
Parking/Tolls			
Other Costs (identify)			
TOTAL COST			

Submit the request via email to HealthChoices Director Jacqueline Miller, jmiller@joinder.org.

***If approved, receipts for reimbursement and a completed Post-Training Survey (Attached) must be submitted to LCJB HealthChoices <u>within 7 days</u> of the last day of training.**

HealthChoices Approval:_____Date:_____

Lycoming-Clinton HealthChoices

POST TRAINING SURVEY

All individuals who attended the training are required to complete this survey, Please return completed surveys with your invoice to LCJB HC Director, Jacqueline Miller.

1. Name and title of staff who completed the training: _____

2. What are the most useful ideas derived from the training, that you will apply in your work with HealthChoices members?

3. Did this training event offer "train the trainer" instruction or provide information that could be used to educate others in your program or agency? If yes, would you be interested in sharing the training information with other providers in our Lycoming-Clinton HealthChoices network?

4. Would you recommend this training to other professionals? Why or why not?