

Developmental Disabilities Resource Board  
**Training Stipend for Direct Support Professionals  
And their Immediate Supervisors  
APPLICATION**

**Request for DDRB Training Stipend:**

**This form must be turned in prior to registering for the training. Once reviewed by the DDRB, the request form will be returned to the individual indicating final funding decision.**

Stipend Request Date: \_\_\_\_\_ Class Start Date: \_\_\_\_\_

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (State) (Zip Code)

Approved by Supervisor: \_\_\_\_\_ Date: \_\_\_\_\_  
(Supervisor's signature required)

Employer: \_\_\_\_\_

I am interested in the following training opportunity: (attach official course/training description)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Total Cost for Registration:** \_\_\_\_\_ (20% of total registration  
**Less co-pay** \_\_\_\_\_ not to exceed \$25.00)  
**DDRB Stipend Request:** \_\_\_\_\_

The DDRB will pay the registration fee and eligible expenses, less the co-pay, up to a maximum of **\$500.00** per fiscal year. Fees related to late registration, travel and lodging are not covered.

**Choose one of the following:**

☐ Reimbursement. I have enclosed the official training description and itemized paid receipt for tuition and eligible expenses. I understand my final grade and/or certificate of completion must be received within **60** days of training completion.

☐ Pre-registration. I have enclosed the official training description that includes the name of institution for DDRB payment. I am requesting the DDRB send its portion of the registration to me and I will forward the check along with my portion of the registration and registration forms to the institution conducting the training. I understand all receipts, final grade and/or certificate of completion must be received within **60** days of training completion.

Make Check Payable to: \_\_\_\_\_

Send Check to: Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

<b>DDRB Review:</b>	Date: _____ Amount Approved: \$ _____
	<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved
	DDRB Representative Signature: _____

**Developmental Disabilities Resource Board**  
**Training Stipend Program for Direct Support Professionals**  
**And their Immediate Supervisors'**  
**TRAINING FEEDBACK**

*This form, along with final grade and/or certificate of completion, must be received within 60 days of training class/course completion.*

Title of Training Event Attended \_\_\_\_\_

Instructor: \_\_\_\_\_

Dates of Training: \_\_\_\_\_ Cost: \_\_\_\_\_

Location of Training: \_\_\_\_\_

**1. How would you rate the instructor? Check all that apply or add:**

- |  |                                      |                                       |
|--|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Energetic     | <input type="checkbox"/> Interesting | <input type="checkbox"/> Off-task     |
| <input type="checkbox"/> Boring        | <input type="checkbox"/> Likable     | <input type="checkbox"/> Disorganized |
| <input type="checkbox"/> Knowledgeable | <input type="checkbox"/> Long-winded | <input type="checkbox"/> _____        |

**2. How would you rate the overall content of the training?**

- ☐ Excellent      ☐ Good      ☐ Fair      ☐ Poor

**3. Will you be able to apply what you learned to your current job?**

- ☐ Yes      ☐ No

Explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. How will this training enable you to improve the quality of life for the individual(s) you serve?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Would you recommend other direct support professionals and their immediate supervisors to attend this training opportunity?**

- ☐ Yes      ☐ No

Explain: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Address: \_\_\_\_\_  
(Street) (State) (Zip Code)