

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: _____

Less co-pay **-\$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: _____

DDRB Review:	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)