



U.S. Department of Labor  
Employment and Training Administration

OMB Control No. 1205-0439  
Expiration Date: ~~79/304/20163~~

## Project Synopsis Form ETA 9106

### National Emergency Grant National Dislocated Worker Grants Electronic Application System

State of _____	Amount of Funding Request \$ _____	Amount Approved by DOL \$ _____
Project Name: _____		
Project Type: <input type="checkbox"/> Regular <input type="checkbox"/> Disaster <input type="checkbox"/> Trade Dual Enrollment <input checked="" type="checkbox"/> <u>Trade Health Insurance Coverage (HCTC)</u>		
Application Type: <input type="checkbox"/> Full <input type="checkbox"/> Emergency (If Emergency – reason : _____ )		
For <b>Regular</b> Project Application ONLY:		
Description/Type of Eligible Dislocation Event : <input type="checkbox"/> Plant Closure/Mass Layoff <input type="checkbox"/> Community Impact Layoffs <input type="checkbox"/> Military Installation <input type="checkbox"/> Industry Wide <input checked="" type="checkbox"/> <u>Higher Than Average Demand for Services from Dislocated Service Members</u>		
Description of Activities to be Provided: _____		
For <b>Disaster</b> Project Application ONLY:		
Name/Description of Disaster Event/Activities to be Provided: _____		
Date of FEMA Declaration of Eligibility for Public Assistance: _____ ; or		
<u>Date of Emergency or Disaster Situation of National Significance:</u> _____		
<u>Name of Federal Agency Declaring Disaster Event (if other than FEMA):</u> _____		
Target Groups (check all that apply): <input type="checkbox"/> Unemployed Due to Disaster <input type="checkbox"/> Long-Term Unemployed <input type="checkbox"/> Dislocated Workers <input checked="" type="checkbox"/> <u>Evacuees from a Declared Disaster Area</u>		
For <b>Trade Health Insurance Coverage</b> Project Application ONLY:		
<del>State-based Qualified Health Insurance Coverage Programs Selected by State:-</del> <del>_____ Continuation Provision High Risk Pool _____ State Employees _____ State Employee Comparable</del> <del>_____ Joint State-Private Non-Pool _____ Joint State-Private Pool _____ Non-federally Financed</del>		
Applicant Contact Person:		
Street Address 1: _____		
Street Address 2: _____		
City: _____ State: _____ Zip Code _____		
Telephone: _____		
FAX: _____		
Email: _____		
Planned Number of Participants: _____	Planned Entered Employment Rate: _____ %	
Planned Cost Per Participant: \$ _____	Actual Cost Per Participant in Prior PY: \$ _____	
% of Planned Participants Receiving NRPs: _____	Planned Earnings: _____ %	
Counties Included in Project Service Area: _____		

Project Operator Listing:

**Public Burden Statement:**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB Control number. Respondents' obligation to complete this form is required to obtain or retain benefits ( PL: 107-210). Public reporting burden for this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. This is public information and there is no expectation of confidentiality. Send comments regarding this burden estimate to the U.S. Department of Labor, Office of National Response, Room C-5311, Washington, D.C. 20210 (Paperwork Reduction Project 1205-0371).

ETA Form 9106(March 2004)