U.S. Department of Labor
Employment and Training Administration

OMB Control No. 1205-0439
Expiration Date: ~~7~~9/3~~0~~1/201~~6~~3

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: ___~~Regular~~Employment Recovery ___Disaster Recovery ___Trade Dual Enrollment ___~~Trade Health Insurance Coverage (HCTC)~~

Application Type: ___Full ___Emergency
(If Emergency – reason : _____)

For ~~Regular~~**Employment Recovery** Project Application ONLY:

Description/Type of Eligible Dislocation Event : ___Plant Closure/Mass Layoff ___Community Impact Layoffs ___Military Installation ___Industry Wide ___Higher Than Average Demand for Services from Dislocated Service Members

Description of Activities to be Provided:

For **Disaster Recovery** Project Application ONLY:

Name/Description of Disaster Event/Activities to be Provided:_____
Date of FEMA Declaration of Eligibility for Public Assistance: _____; or

Date of Eemergency or ~~d~~Disaster ~~s~~Situation of ~~n~~National ~~s~~Significance: _____

Name of Federal Agency D~~d~~eclaring ~~d~~Disaster eEvent (if other than FEMA): _____

Target Groups (check all that apply): ___Unemployed Due to Disaster ___Long-Term Unemployed ___Dislocated Workers ___Evacuees F~~f~~rom a ~~d~~Declared ~~d~~Disaster Aarea

~~For **Trade Health Insurance Coverage** Project Application ONLY:~~

~~State-based Qualified Health Insurance Coverage Programs Selected by State:~~
~~___Continuation Provision High-Risk Pool ___State Employees ___Sate Employee Comparable~~
~~___Joint State-Private Non-Pool ___Joint State-Private Pool ___Non-federally Financed~~

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).