## Request for Proposals Cover Sheet – One-Stop: Adult and Dislocated Worker Services

**Lead Applicant:** Click or tap here to enter text.

**Indicate Area to be served (select one or both):** Allegheny County  City of Pittsburgh

1. **Contact Information**

Organization Name: Click or tap here to enter text.

Address: Click or tap here to enter text.

City: Click or tap here to enter text. State: Click or tap here to enter text. Zip Code: Click or tap here to enter text.

Principal Contact Person: Click or tap here to enter text. Title: Click or tap here to enter text.

Phone: xxx-xxx-xxxx Fax: xxx-xxx-xxxx Email: Click or tap here to enter text.

Fiscal Contact Person: Click or tap here to enter text. Title: Click or tap here to enter text.

Phone: xxx-xxx-xxxx Fax: xxx-xxx-xxxx Email: Click or tap here to enter text.

Executive Director: Click or tap here to enter text.

Phone: xxx-xxx-xxxx Fax: xxx-xxx-xxxx Email: Click or tap here to enter text.

1. **Legal Information**

Type of organization: For-profit:  Non-Profit:  Government or School District:

Federal Employer Identification Number (FEIN): Click or tap here to enter text.

Please provide your current [DUNS Number](https://www.dnb.com/duns-number/get-a-duns.html): Click or tap here to enter text.

Please provide your current [CAGE Code](https://cage.dla.mil/): Click or tap here to enter text.

1. **Requirements / Documents** *(proposals submitted without these documents will be considered incomplete, please see associated links for more information and instructions as to how to acquire them) Please note that a single copy of all requirements below must be submitted for EACH Partner, in addition to the lead applicant (if applicable).*

* Registration in the [System for Award Management](https://www.sam.gov/SAM/) (SAM)
* Completed Pre-award Assessment ([complete online](https://www.surveymonkey.com/r/ZKN2B6W))
* Most recent financial audit
* Certificate of Liability Insurance
* Certificate of Worker’s Compensation Insurance
* W9

1. **Budget Information**

**Budget Summary:**

|  |  |
| --- | --- |
|  | **Total** |
| **Total Amount Requested** |  |
| **Active WIOA A/DW Registrants[[1]](#footnote-1)** |  |
| **Cost per Active Registrant[[2]](#footnote-2)** |  |

**Leveraged Funds:**

* + Please list all other sources of funding that will support your proposed program, if applicable.

|  |  |
| --- | --- |
| **Funding Source** | **Amount** |
|  | $0.00 |
|  |  |
|  |  |
|  |  |
|  |  |
|  | ***Total*** |
|  |  |

1. **Certifications/Authorization**

I certify that the above-named organization is legally authorized to submit this application, that the contents of the application are truthful and accurate, and that the above-named organization agrees to comply with all requirements of the RFP. Our organization understands this program operates on a reimbursement model, and we are prepared to front costs related to said program until requirements for reimbursement are met and funds are available for reimbursement.

Printed Name of Authorized Representative Title of Authorized Representative

Signature of Authorized Representative Date

1. See RFP Statement of Work for definition of Active Registrants [↑](#footnote-ref-1)
2. Divide number of active registrants by total amount requested [↑](#footnote-ref-2)