New York State Department of Health
Office of Primary Care and Health Systems Management
Center for Health Care Policy and Resource Development
Division of Workforce Transformation

SOLICITATION OF INTEREST #20298

Increasing Training Capacity in Statewide Healthcare Facilities

Attachment #2
Application Form

Funding Amount Requested	$

Contact Information*			
Applicant Name		**Name of Project Coordinator**	
Contact Person, Title		**Contact Person, Title**	
Address		**Address**	
Phone #		**Phone #**	
Fax #		**Fax #**	
Email Address		**Email Address**	

*This is who will be contacted if awarded to negotiate the work plan and budget.

Please be sure to complete all sections below, including signing the attestation, before submitting.

Applicant Information:

1. Is the applicant organization (please check one):
   - A General Hospital certified or licensed under Article 28 of the Public Health Law (PHL)
     Yes or No
   - Diagnostic and Treatment Centers certified or licensed under Article 28 of the Public Health Law (PHL)
     Yes or No
   - A Residential Health Care Facility (Nursing Home) certified or licensed under Article 28 of the Public Health Law (PHL)
     Yes or No
2. Please provide the Applicant's New York State Operating Certificate Number: _________________
3. Please indicate the discipline(s) proposed to be trained in this proposal:

   ____

4. Please indicate if the training proposed in this proposal will be offered by facility training staff or by a contracted entity:

   ____

5. Please provide the number of staff that are being proposed to receive training:

   ____

6. Please provide the training curriculum to be used or if a training curriculum will be developed:

   ____

Project Description: (Please complete on a separate document and attach to this Application form).

1. Please provide a detailed description of the project or program and the actions and activities that will be undertaken to realize it. Include the distinct features of your project including (1) the purpose it serves and (2) how this purpose aligns with the Department of Health's stated goal of increasing training capacity of the healthcare workforce.

2. Please provide a projected timeline for implementation with proposed actions and deliverables.

3. What is the current state of training programs and/or training project development?

4. Which type of job(s) or worker(s) does the training program target? Explain how this fits the criteria of an "in-demand" job category where training is needed and how your approach is responsive to the needs of the healthcare industry.
    a. What specific types of jobs and job titles will the program or project prepare target? Refer to O*Net at https://www.onetonline.org/ and provide O*Net codes for a maximum of 10 titles in which the participant will be trained.

5. Explain the need for funding through this program, including why funding is necessary to complete the project and why funding for this project cannot be acquired from other public funding sources (NYS Department of Labor, Workforce Investment Fund, etc.). How does the funding you are seeking make it possible to reach your program or project goals, such as change to the number of participants, types of training that can be offered, or other results relevant to your goals?

6. What is the applicant's experience with projects of similar size and scale to the one proposed in this application? Please give specific examples of results and successes that demonstrate the applicant's established track record of effective training programs.

7. Describe any industry and/or community partnerships that have been or will be developed that relate to or will support the proposed project.

Attestation:
Please complete, enter the organization's legal name, and information required below, and sign the attestation before submitting.

Funding Opportunity: Increasing Training Capacity in Statewide Healthcare Facilities

Organization: «Enter Organization's Legal Name»

Contract Term: October 1, 2023 – September 30, 2025

Consistent with the Solicitation of Interest for the above referenced funding opportunity and the information provided through the application cover page, the individual authorized by the above-named organization to submit this form attests that the information submitted is accurate and attests that the funding will be used to expand training capacity in health care facilities. If the information is determined to be inaccurate, the Department can adjust the contract award amount or terminate the contract if needed. The individual authorized by the above-name organization attests to the organization's capability and willingness to enter into a binding Master Grant Contract with NYSDOH without change or amendment.

Name of Person Authorized to Attest: ______________________________

Title of Person: _______________________________

Electronic Signature: ________________________________

Date: ____________________________

The completed and signed attestation must be included with the application.