**DSRIP Statewide Investment Behavioral Health**

**Workforce Development Program**

**EMPLOYER APPLICATION FORM AND INFORMATION**

***Employer Application Guidance and Checklist***

**The Employer Application, and Sections C and D in particular, are critical to the provider’s application**. **Each statement of Organization Need for Provider and Provider Retention Plan must be specific to the applicant.** Application review will be a competitive process. The Employer Application will be used by the Application Review Committee to evaluate need, the provider’s compatibility with the organization, and the likelihood of this applicant’s long-term retention by your organization.

\_\_\_\_1. **Section A**: Completed **Organization Information *(complete per each individual provider applying)***

\_\_\_\_2. **Section B:** Completed **Vacancy and Staffing Information for Site *(complete per each individual provider applying)***

\_\_\_\_3. **Section C:** Attached **Statement of Organization Need *(complete per each individual provider applying)***

\_\_\_\_4. **Section D:** Attached **Organization Retention Plan *(complete per each individual provider applying)***

\_\_\_\_5. **Section E:** Completed **Letter of Commitment *(complete per each individual provider applying)***

**Section A: Organization Information**

Name of Organization

Type of Organization:

[ ] Community Mental Health Center (inclusive of community-based mental health centers, substance use programs, and psychiatric day treatment programs)

[ ]  Behavioral Health Community Partner or their Affiliated Partner or Consortium Entity

[ ]  Organization Contracted with an ACO to Provide IHT

Corporate Address

List all sites

CEO or Equivalent *(please write-in name)*:       Official Title:

CMO, Medical Director, or Clinical Director or equivalent *(please write-in name)*:

Official Title:

Contact Person (**person completing form**)

Contact Person’s Title

Telephone (   )    -

Fax (   )    -

Email Address

**Section B: Vacancy and Staffing Information for Site**

With this applicant, is the organization seeking to:

 … **fill a vacancy**  [ ]  Yes [ ]  No *or*

 … **fill a new position** [ ]  Yes [ ]  No *or*

… **retain a valued provider** [ ]  Yes [ ]  No

If the position is a **vacancy**, how long has it been (or will it have been) vacant?       or [ ]  N/A

*Please describe challenges in hiring for this position or other provider vacancies in Section C: Statement of Organization site need.*

If the position is a **new expansion** position how long has it been or will it be vacant?       or [ ]  N/A

Do you have a waiting list for new patients?

 \*\*If yes, how long on average before initial visit?

What is your turnover ratio for clinicians? (If known)

**Section C: Statement of Organization Need**

Please attach a separate page with 1-2 paragraphs describing how this particular applicant for the Behavioral Health Workforce Development Program meets the needs at your organization and how he/she will benefit the patients and the community that they will be serving. **Please outline why your organization chose to bring this particular provider on board and/or why their retention is a priority for your organization.**

Examples of areas toaddress in this statement include:

 *- language skills,*

 *- cultural competency,*

 *- clinical experience treating prevalent disease within community,*

 *- leadership skills, organization hardships prior to hiring provider,*

If this is a *vacancy replacement*, please also describe the void and hardships the applicant will fill.

If this is an *expansion position*, please include details of your organization’s needs as they pertain to growth and reasons for the expansion.

**Section D: Organization Retention Plan**

Please attach a separate page with 1-2 paragraphs describing your site’s personalized plan for retaining this specific provider during and after the loan repayment period.

This should include a description of the specific nature of your organization’s support for this provider’s career development, including opportunities for continuing education, participation in innovative clinical initiatives, research and clinical teaching.

**A comprehensive retention plan takes into account how to ensure that this provider remains engaged and effective. The retention plan goes beyond financial incentives, and instead, lays out a strategic plan for addressing the reasons a provider might leave, and exploring all options for retaining this provider.**

The retention plan further addresses:

 *- The results of (a) face-to-face discussion(s) with the provider in order to gain a better*

 *understanding of what their career goals are and how they hope to accomplish them.*

 *- How the organization will maintain an enjoyable, collaborative, and supportive working*

 *environment for this provider through mentoring, team-building, training, flexible schedule, etc.*

 *- Opportunities for personal and professional growth*

 *- The goals that have been set for this provider*

 *- Skill development opportunities, for leadership, specialization, teaching, etc.*

**Section E: Letter of Commitment**

Please attach a separate page a letter of commitment describing how your organization will support this provider throughout their 4-year commitment to the DSRIP Statewide Investments Behavioral Health Workforce Development Program. . Please feel free to reference Sections C and D for supporting details; letters need not exceed 1-2 pages to be effective.

Please make sure to certify that your organization commits to do the following:

 *- Free provider one day per quarter to participate in the Quarterly Learning Days*

 *- Willing to accept salary replacement for your organization to cover these*

*Quarterly Learning Days*

As a representative of       (organization), we are committed to place a qualified applicant for loan repayment for which our organization is deemed eligible. We have a specific interest in the following applicant:       and recommend this applicant for approval for loan repayment with a commitment by the applicant and organization to work at our community based organization.

**SIGNATURE OF THE PRESIDENT/CEO or equivalent OF THE ORGANIZATION**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

Print Name Title