# DSRIP Statewide Investments

# Primary Care/Behavioral Health Special Projects Program

**Application**

**Date of Submission**

## Name of Organization

Organization Address

Type of Organization/entity:

Community Health Center

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

Emergency Service Provider

Community Service Agency

Organization Participating in a Community Partner Community Partner or their Affiliated Partner or Consortium Entity

Organizations Contracted with an ACO to Provide In-Home Therapy

Primary Contact

E-Mail Address

Work Telephone        Primary

Cell phone        Primary

Project Lead Provider

E-Mail Address

Work Telephone        Primary

Cell phone        Primary

Provider Type

Physician  Physician Assistant

Psychologist  Licensed Certified Social Worker (LCSW)

Psychiatrist  Licensed Independent Clinical Social Worker (LICSW)

Advanced Practice Registered Nurse  Licensed Mental Health Counselor (LMHC)

Psychiatric Clinical Nurse Specialist  Licensed Marriage and Family Therapist (LMFT)

Nurse Practitioner  Licensed Alcohol and Drug Counselor I (LADC1)

Date of hire

## Project Title:

**Type of Project**:  Special Project

Mini-Fellowship

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| **SUMMARY OF SPECIAL PROJECT (limit to 250 words)** **This summary should be developed for a public audience and include the project goal, how it will benefit the organization, a high-level description of project activities, and how the funding will be used.** |

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| **Please list clinicians/staff members impacted by and/or engaged in the project. Please be sure to identify clinician/staff member roles, including the lead provider, as well as the total number or clinicians/staff members impacted by and/or engaged in the project.** |

**Total Grant Request:**      *(Grants will be up to $40,000)*

**CEO/Executive Director Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_**