**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