# DSRIP Statewide Investments

# Primary Care/Behavioral Health Special Projects Program

**Application: Cover Sheet**

**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 or their Affiliated Partner or Consortium Entity

Organizations Contracted with an ACO to Provide In-Home Therapy

Primary Application Contact

E-Mail Address

Work Telephone

Project Lead Provider

Project Lead Provider Title

Project Lead Provider Pronouns

E-Mail Address

Work Telephone

CEO/Equivalent

E-Mail Address

Project Lead Provider – Languages Spoken (*other than English*)

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 \_\_\_\_\_\_\_\_\_\_\_\_\_**

**To Be Completed by the Lead Provider**

**Data Collection:***The following questions are optional and are for internal data collection purposes only. Your answers will not be included in any materials received by our external review committee. The information provided will not be used in making final award decisions. These answers will be used to understand the makeup of our workforce, how it reflects to the populations served in our communities, and to inform what additional resources could be provided.*

Which of the following best describes your race/ethnicity? [Please check all that apply.]

White

Hispanic, Latino, or Spanish

Black or African American

Asian

American Indian or Alaskan Native

Middle Eastern or North African

Native Hawaiian or other Pacific Islander

Bi-Racial/ Multi-Racial

Some other race, ethnicity, or origin:

Prefer not to say

Please feel free to elaborate on your response.

What is your gender identity? [Please check all that apply.]

Female

Male

Non-Binary

Gender Fluid

Prefer to self-describe:

Prefer Not to Say

What is your sexual orientation? [Please check all that apply.]

Straight

Lesbian

Gay

Bisexual

Transgender

Queer

Intersex

Asexual

Pansexual

Prefer to self-describe

Prefer not to say