**Massachusetts League of Community Health Centers & MassGeneral Brigham (MGB)**

***Behavioral Health Workforce Incentive Program***

**Application**

*Please submit all completed Application materials to BHWIP@massleague.org by*

*Friday, August 26th, 2022, at 5:00pm EST.*

***Application Checklist***

This Checklist reflects core application requirements. You must check each item on this checklist and sign and date below to confirm that all documentation has been included accordingly.

Please keep a copy of all application materials for your records and note that no revision to your application can be made following your submission.

Proof of U.S. citizenship or status as a permanent/legal resident

Copy of degree

Copy of license

Copy of curriculum vitae/resume

Submission of the required three essays

Submission of two Letters of Recommendation – *at least one letter must be from a supervisor who can independently evaluate your work and support your application and one letter from a person of your choice.*

**Print Name**



**Date**

**General Information:**

Name

E-Mail Address

Name of Community Health Center

Organization Site Address

*If your health center has more than one address, please use the site address of the location you are based out of.*

CEO/Equivalent Name

CEO/Equivalent E-Mail Address

CFO Name

CFO E-Mail Address

**Provider Type**

Psychiatrist

Psychologist

Psychiatric Mental Health Nurse Practitioner (PMHNP)

Licensed Independent Clinical Social Worker (LICSW)

Licensed Certified Social Worker (LCSW)

Licensed Mental Health Counselor (LMHC)

Licensed Marriage and Family Therapist (LMFT)

Licensed Alcohol and Drug Counselor 1 (LADC1)

Start Date at Organization

Confirm Full-Time Employment Status

– *as defined by your organization*

Are you currently fulfilling any other service obligation, i.e. National Health Service Corp, the MDPH State Loan Repayment Program, DSRIP Student Loan Repayment Program, etc.?

If yes, please provide the name of the program.

*Please note, any service obligation to the National Health Service Corp, the MDPH State Loan Repayment Program, or other loan repayment programs must be completed in order to be eligible for this program. If the applicant is part of the Public Service Loan Forgiveness Program, they are eligible to apply.*

What language(s) if any, other than English, do you speak at home and/or in your community or workplace?

Please check all that apply:

Arabic

Cantonese

Cape Verdean Creole

French

Haitian Creole

Khmer

Mandarin

Portuguese

Russian

Sign Language

Spanish

Vietnamese

None

Other

**Essays:**

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| **COMMITMENT TO COMMUNITY HEALTH (limit to 500 words)****: Please provide a brief statement describing your commitment to providing culturally competent care to BIPOC, and underserved communities within a community health center setting. This summary can include information related to lived experiences, work experiences, volunteer work, and/or future career goals.** |

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| **EQUITABLE CARE (limit to 500 words): Please provide a brief statement describing your understanding of historical and current health equity problems in behavioral and physical health. This summary can include your vision of equitable care and how you use this understanding and vision while providing culturally competent care within a community health center setting.** |

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| **QUALIFICATIONS (limit to 500 words): Based on the goals of trying to create greater access to BH services in BIPOC communities, please provide a brief statement describing why your qualifications and career aspirations make you a strong candidate for this program.** |

**Underrepresented students representing a diverse population, including but not limited to, racial/ethnic minorities (e.g., Black or African American, Hispanic/Latinx, Asian American and Pacific Islander, Native American), individuals from rural communities, and students who are linguistically diverse are encouraged to apply.**

**By providing my signature below, I commit to completing two years of obligated service at my identified community health center. I understand that failure to complete this obligated service term will result in repaying a pro-rated amount of funds not earned to the MassLeague. Contracts will reflect this obligation.**

**Print Name**      

**Date**



**CEO/Equivalent Print Name**      



**Date**

**Diversity Survey:***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.*

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

*self-description*

Some other race, ethnicity, or origin:

*self-description*

Prefer not to say

Please feel free to elaborate on your response.

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

Female

Male

Transgender (ftm)

Transgender (mtf)

Non-Binary

Gender Fluid

Prefer to self-describe:

*self-description*

Prefer Not to Say

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

Straight

Lesbian

Gay

Bisexual

Queer

Asexual

Pansexual

Prefer to self-describe

*self-description*

Prefer not to say