This application is for organizations seeking funding from the Maryland Department of Labor under the Career Pathways for Healthcare Workers Program. Please complete all fields of this application and submit with the other required documentation by **11:59 PM on July 28, 2023. Completed applications should be submitted via email to Brittney Hansen at** [**brittney.hansen@maryland.gov**](mailto:brittney.hansen@maryland.gov)**. Submissions must include all required documents listed below and should be submitted as one PDF file in a single email. In addition, the Program Budget should also be submitted as an Excel sheet (.xlsx).**

Prior to submission, review the required and optional documents table below to ensure a complete application. Applicants are also encouraged to carefully review the [**Career Pathways for Healthcare Workers Program Policy**](https://labor.maryland.gov/employment/mpi/mpi6-23.pdf) prior to completing this application.

**Career Pathways for Healthcare Workers Program Application Submission Checklist**

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| **REQUIRED DOCUMENTS** | **OPTIONAL DOCUMENTS** |
| * **Career Pathways for Healthcare Workers Grant Application** | * **Additional Letter(s) of Support from Partners** |
| * **Career Pathways for Healthcare Workers Budget (.xlsx)** | * **Sample Program Curriculum** |
| * **Required Match Documentation** | * **Special Promotional Materials** |
| * **Letter of Support from Partner (Maryland-based Historically Black College or University (HBCU) or Community College)** |  |
| * **Signed W9 Form** |  |
| * **Certificate of Good Standing** |  |
| * **If your organization is exempt from taxation under IRC 501(c), include the determination letter from the IRS.** |  |

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| **SECTION 1: APPLICANT INFORMATION** | | |
| **1** | **Organization Name** |  |
| **2** | **Employer Identification Number (FEIN)** |  |
| **3** | **Point of Contact Name** |  |
| **4** | **Point of Contact Title** |  |
| **5** | **Point of Contact Email Address** |  |
| **6** | **Point of Contact Phone Number** |  |
| **7** | **Organization Street Address** |  |
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| **SECTION 2: TRAINING FUND INFORMATION** | |
| **8** | **Has the applicant created, with an employee organization or union and a collective bargaining agreement, a training and upgrading fund that provides educational and job training programs and benefits health care workers? Applicants must submit a letter of support from the employee organization/union.**  **Yes  No**  **If the answer is yes, complete A-E below. If the answer is no move to section 3:** |

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| **A** | **Training Fund Name** |  |
| **B** | **Training Fund Address** |  |
| **C** | **Training Fund Email** |  |
| **D** | **Training Fund Employer Identification Number (FEIN)** |  |
| **E** | **Training Fund Point of Contact Name** |  |

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| **SECTION 3: APPLICANT AND PARTNER PROFILES & PROGRAM EXPERIENCE** | |
| **9** | **Provide a brief profile of the applying organization.**  *See page 3 of the Career Pathways for Healthcare Workers Program policy for information on eligible entities for this grant funding.* |
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| **10** | **Provide a brief profile of the Maryland-based Historically Black College or University (HBCU) or Community College with whom your organization will partner to provide training. Please describe their role in the project and any experience they have providing training to healthcare workers.** |
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| **11** | **Provide a brief profile and describe the role any additional partners will play in the project. If none, state N/A.** |
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| **SECTION 4: DESCRIPTION OF PROPOSED USE OF FUNDING (PROJECT PLAN)** | |
| **12** | **Describe the proposed plan for the use of funding. Identify and provide a description of training programs that will be offered. Please provide Labor Market Information to support the industry need for the training identified.**  *Note- Training programs must be no longer than 12 months in length.* |
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| **13** | **Provide details on how the applying organization has been involved with the training of healthcare workers relating to:**   * **A list of training programs that healthcare workers have requested to attend during the immediately following calendar year,** * **Information on previous training programs that have been offered during the proceeding calendar year, including information on training program costs, and** * **Information on previous training programs that the applicant has paid for healthcare workers to attend during the preceding calendar year, including information on training program costs.** |
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| **14** | **Eligible program participants will be current employees. Describe how the applying organization will identify program participants.**  *See page 3 of the Career Pathways for Healthcare Workers Program policy for definition of healthcare worker.* |
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| **15** | **Provide details on how the training will help upskill or increase the skillsets of the healthcare workers.**  *Applicant should describe the career pathway of the healthcare worker, if applicable.* |
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| **16** | **Participants who complete training must receive a wage increase that is commensurate with the current Labor Market trends for the jurisdiction in which they are employed within 90 days of completion of training. Provide details on how your organization will adhere to this requirement.**  *Applicant should include occupation and wage increase upon completion of training.* |
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| **17** | **Describe any supportive services and benefits that will be provided to participants and explain how this will support participants in completion of the training program.** |
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| **18** | **Describe the timeline for all project’s key activities.**  *Grants will begin on October 1, 2023 and end on September 31, 2024. Applicants should write a 12-month timeline that details the project’s key activities per month.* |
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| **19** | **When funds awarded under the grant are exhausted or the project has ended, how will the efforts initiated under your proposal be sustained?** |
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| **SECTION 5: PROGRAM EVALUATION AND REPORTING TARGETS** | | |
| **20** | **Complete the chart below to identify the program’s targeted key performance outcomes.** | |
| **A** | Number of healthcare workers enrolled in training. |  |
| **B** | Number of healthcare workers who will graduate or complete training. |  |
| **C** | Number of healthcare workers to obtain an industry-recognized certification or credential. |  |
| **21** | **Describe how the applicant will track and evaluate each of the performance outcomes identified above in questions A-C**. | |
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**Instructions for Section 6: Program Financial Information**

Complete this section for the Career Pathways for Healthcare Workers Program grant requested. Information in this section **must** be consistent with the itemized the Career Pathways for Healthcare Workers Budget provided with the application. The Program Budget should be completed and submitted as an Excel document (.xlsx) along with this application. Please reconcile Section 5 of this application with the associated Program Budget prior to submission.

**Commitment of non-State Matching Funds**

The Career Pathways for Healthcare Workers Program requires that applicants can demonstrate a dollar-for-dollar (100%) cash match of the requested grant amount. Matching funds may be either monetary or in-kind. Applicants must clearly identify all additional leveraged resources in the itemized the Career Pathways for Healthcare Workers Budget and include the total amount in Question C from Section 5 of this application. Review these items prior to submitting this application.

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| **SECTION 6: PROGRAM FINANCIAL INFORMATION** | | |
| **22** | **Provide the following financial information about the funding requested.** | |
| **A** | Total grant amount requested | $ |
| **B** | Amount of matched funding | $ |
| **C** | Amount of any other leveraged resources (beyond the match) | $ |

**Applicant Affirmations and Submission**

Prior to signing below, review all sections of this application for completion and accuracy. Review the [**Career Pathways for Healthcare Workers Program Policy**](https://labor.maryland.gov/employment/mpi/mpi6-23.pdf) for any additional requirements associated with this program. Ensure that all required attachments and any desired optional attachments are included in the final submission.

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|  | **AFFIRMED** |
| The undersigned affirms that the applicant organization is in good standing with the Comptroller of Maryland and the Maryland Department of Labor. | |  | | --- | |  | |
| The undersigned affirms that the contents of this application are true, verifiable, and in compliance with all requirements put forth in the program policy.  The undersigned affirms that there will be no cost to the participant for participating in training.  The undersigned affirms that every participant who completes the training will receive a wage increase within 90 days of completing training. | |  | | --- | |  |  |  | | --- | |  |  |  | | --- | |  | |

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| **Applicant Full Name** |  |

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| **Applicant Signature** | **Date** |
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