



HWRI GRANT APPLICATION

January 1, 2019 – December 31, 2019

Section 1 - Applicant Information

Complete all fields

First Name: _____ Last Name: _____

Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Preferred method of communication
(check all that apply):

Email

Home Phone

Cell Phone

Work Phone

I am a **U.S. citizen, permanent alien** or **resident alien** authorized to work in the U.S. Yes No

I have at least one year of experience as a **permanent New York State employee**. Yes No

Section 2 - Employment Information

Complete all fields

Agency employed by: OMH* DOCCS OPWDD

*OMH Employees Only: I am a participant in OMH's Nurse Development Program. Yes No

Are you currently a registered nurse? Yes No - If yes, highest degree held: _____

Current Job Title: _____ Work Shift: _____

Work Location

Facility Name: _____

Facility Address: _____

City/State/Zip: _____ County: _____

Section 3 - Nursing-Related Education Goal

Check boxes as appropriate & enter NoC/P if known

I am already a Registered Nurse and I would like to:

- Begin/continue a higher level degree (check degree level) ___BSN ___MSN ___NP ___DNP ___PhDN
- Begin/continue an advanced nursing certificate program
- Take a single nursing-related course that will help me learn new knowledge, skills or techniques that are aligned with my agency's needs, or help me qualify for additional nursing certifications

I would like to become a Registered Nurse and I would like to:

- Take a course to do any of the following: explore if this career is a good fit for me; strengthen my college-readiness skills; strengthen my English language skills; or take a prerequisite course that would count toward requirements for a nursing degree
- Begin/continue coursework in an accredited nursing program (check degree level) ___ADN ___BSN

Name of College/Program: _____



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Section 4 - Agreement

Please read carefully and check box for each statement below.

- The information on this application is true.
- I will provide any additional documentation requested to support the information on this application.
- If I am approved for a grant allocation I will abide by the Responsibilities of a Program Participant as explained on page 5 of the Participant's Guide (www.pdp.albany.edu/HWRI/) and I will submit a Nursing Grant Request Form (NRGF) to begin using my grant award as soon as I have registered for coursework.
- I understand awards made through this program apply only to eligible activities occurring during the period, January 1, 2019 – December 31, 2019 and funding is contingent on availability.
- I understand that as a condition for program participation, I must maintain at least a 2.0 GPA if I am enrolled in an RN degree program or a 2.5 GPA if I am enrolled in a BSN program, or a 3.0 GPA if I am enrolled in an advanced degree/certification program.
- I understand reimbursements paid to me by The Research Foundation for The SUNY may be considered taxable income. I will follow all federal, state and local requirements regarding reporting and payment of taxes.

Your original signature indicates you have read, understood and agreed to the statements above.

Applicant's Signature: _____ **Date:** _____

Section 5

Other Required Signatures

Educational Mentor:

Print Name

Signature

Date

Agency Representative: (OMH or DOCCS or OPWDD):

Print Name

Signature

Date

Send your completed and signed application to:

OMH

Juanita Goyette
 OMH/Office of Coordinated Nursing
 Services
 44 Holland Avenue – 8th Floor
 Albany, NY 12229
 Phone - (518) 474-8501
 Fax - (518) 474-6909

juanita.goyette@omh.ny.gov

DOCCS

Tracy Boswell, RN, BSN
 DOCCS – Medical Unit
 PO Box 2000
 1156 Route 374
 Dannemora, NY 12929
 Phone - (518) 492-2511 ext.6111
 Fax - (518) 492-2503

Tracy.Boswell@doccs.ny.gov

OPWDD

Susan Gottfried
 OPWDD/Talent Development and
 Training
 44 Holland Avenue
 Albany, NY 12229
 Phone - (518) 473-1190

talentdevelopment@opwdd.ny.gov