PROFESSIONAL DEVELOPMENT PROGRAM
ROCKEFELLER COLLEGE UNIVERSITY AT ALBANY State University of New York

HWRI GRANT APPLICATION

January 1, 2020 – December 31, 2020

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 the 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:** _____

Union Affiliation:

___ None
___ PEF ___ M/C ___ CSEA
___ Other _____

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: _____

This HWRI Grant is funded by the New York State Department of Health (in consultation with NYSDOL) and is administered by The Research Foundation for The State University of New York, through the Professional Development Program, Rockefeller College, University at Albany 1/2020

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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.
- □ I understand awards made through this program apply only to eligible activities occurring during the period, January 1, 2020 – December 31, 2020 and funding is contingent on availability.
- □ If I am approved for a grant award, 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 immediately upon receipt of my tuition bill**. I realize that delayed submission puts me at risk of losing my grant, at the discretion of my agency.
- □ 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

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DOCCS

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