New York State Department of Health
Office of Primary Care and Health Systems Management
Center for Health Care Policy and Resource Development
Division of Workforce Transformation

SOLICITATION OF INTEREST #20298

Increasing Training Capacity in Statewide Healthcare Facilities

Attachment #3
Project Proposal

Applicant Name	
Applicant's Operating Certificate #	
Applicant's Proposal Name	

Please be sure to complete all sections below, including signing the attestation, before submitting. Applicant may submit proposals to train more than one discipline. If Applicant is submitting proposals to train more than one discipline, Applicant will complete **ONE** project proposal per discipline. **Applicant will use this form and complete for each additional training proposals per discipline.**

Applicant Information:

Applicants Proposed Training Location(s):____

Applicant's Proposed Target Discipline(s):____

Applicant's Proposed Numbers of Target Discipline(s) to be trained:________________________________

Applicant's Proposed Training Dates:____

Applicant Proposal:

To support a steady pipeline of high-quality healthcare professionals, the goal of this funding is to increase the training capacity of medical institutions. Please provide a narrative description of the proposal to increase training which addresses each of the elements below.

- The facility's specific training needs
- The facility's challenges in meeting the defined needs
- The facility's description of the plan to increase training capacity
- How the proposed training program will meet the facility's specific goals
- What metrics will be used to evaluate the facility's proposed training program

PLEASE INDICATE: Funding Requested includes training program for multiple disciplines? Yes ☐ No ☐
PLEASE INDICATE: # of training disciplines: ____

Funding Amount Requested per discipline (If proposal includes training program for multiple disciplines; if indicated "no" above or 1 this amount will represent a total funding request):

$____

Attestation:
Please complete, enter the organization's legal name, and information required below, and sign the attestation before submitting.

Funding Opportunity: Increasing Training Capacity in Statewide Healthcare Facilities

Organization: «Enter Organization's Legal Name»

Contract Term: October 1, 2023 – September 30, 2025

Consistent with the Solicitation of Interest for the above referenced funding opportunity and the information provided through the application cover page, the individual authorized by the above-named organization to submit this form attests that the information submitted is accurate and attests that the funding will be used to expand training capacity in health care facilities. If the information is determined to be inaccurate, the Department can adjust the contract award amount or terminate the contract if needed. The individual authorized by the above-name organization attests to the organization's capability and willingness to enter into a binding Master Grant Contract with NYSDOH without change or amendment.

Name of Person Authorized to Attest: ______________________________

Title of Person: ______________________________

Electronic Signature: ________________________________

Date: ____________________________

The completed and signed attestation must be included with the application.