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Applicant Form

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* Indicates required field

1. APPLICANT PROFILE

A. Name of Organization Applying for Funds	B. Parent Company Name (if applicable)
<input type="text"/>	<input type="text"/>
C. SAM.gov Unique Entity ID	D. MMARS Vendor Code
<input type="text"/>	<input type="text"/>

* E. Please indicate which applicant category best aligns to your organization's status (check all that apply)

- ☐ Massachusetts provider
- ☐ Lead applicant from a collaboration of multiple Massachusetts providers
- ☐ Massachusetts education/training institution
- ☐ Massachusetts community-based organization
- ☐ Massachusetts private foundation
- ☐ Owner of an existing workforce program
- ☐ Lead applicant from a regional workforce or training partnership with the capacity to develop and run a workforce program focused on and benefiting employers in Massachusetts.

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☐ Owner of an existing workforce program

☐ Lead applicant from a regional workforce or training partnership with the capacity to develop and run a workforce program focused on and benefiting employers in Massachusetts.

* F. Proposed Program Name

* G. Total Implementation Funds Requested


* H. Does your organization currently have a contract with the state?

2. LEAD APPLICANT CONTACT INFORMATION

A. Primary Contact Person: (notified upon decision of grant award)

* First Name	* Last Name
<input type="text"/>	<input type="text"/>
* Title	* Phone
<input type="text"/>	<input type="text"/>

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*F. Proposed Program Name

*G. Total Implementation Funds Requested

*H. Does your organization currently have a contract with the state?

*Which agency do you currently contract with? Select all that apply.

☐ Department of Mental Health

☐ Department of Public Health

☐ Executive Office of Elder Affairs


☐ Department of Developmental Services

☐ Massachusetts Rehabilitation Commission

☐ Department of Children & Families

☐ Other (fill in field)

2. LEAD APPLICANT CONTACT INFORMATION

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*First Name

*Last Name

*Title

*Phone

*Email

B. Secondary Contact Person:

*First Name

*Last Name

*Title


*Phone

*Email

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Program Description

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1. PROGRAM DESCRIPTION

*A. Program Name

*B. Program Type. Please select which of the following best describes your proposed program.

☐ Pipeline Development and Recruitment Efforts

☐ Professional Development and Retention Efforts


☐ Workforce-Impacting Information Technology (IT) Improvements

*C. Please indicate if this is a program expansion, or brand-new program.

*D1. Please identify target workforce (specific role(s)/position(s)) that will benefit from the program:

☐ Direct Care (DC) Staff; e

☐ Nursing;

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☐ Direct Care (DC) Staff; e

* Program Role Category

☐ Care Coordinators,

☐ Companions,

☐ Developmental Specialists,

☐ Family Partners,

☐ Home Care Aides,

☐ Home Health Aides,

☐ Certified Nursing Assistants (CNAs),

☐ Homemakers,

☐ House Managers,

☐ Job Coaches,

☐ Member Services,

☐ Peer Specialists,

☐ Peer Workers,

☐ Personal Care Aides,

☐ Personal Care Homemakers,

☐ Recovery Coach, Recovery Support Navigator, Therapeutic Mentors,

☐ Residential Counselor,


☐ Resource Coordinators,

☐ Outreach Workers,

☐ Enabling Technology Advocates,

☐ Harm Reduction Specialists,

☐ Other Unlicensed Direct Support Professionals and other DC staff job titles.


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☒ Nursing:

- * Program Role Category**
 - ☐ Licensed Practical Nurses (LPNs).
 - ☐ Registered Nurses (RNs).
 - ☐ Independent Nurses
 - ☐ Nurse Practitioners
 - ☐ Psychiatric Nurse Practitioners/Advance Practice RNs.


☒ Behavioral Health Staff:

- * Program Role Category**
 - ☐ Case Workers/Case Managers.
 - ☐ Mental Health Counselors.
 - ☐ Social Workers.
 - ☐ Substance Use Disorder Workers (e.g., Counselor, CADC, LADC).
 - ☐ Other Behavioral Health Workers.

☒ Community Health Workers (CHWs):

- * Program Role Category**
 - ☐ Certified CHWs.
 - ☐ Other Front-line Public Health Workers.

☐ Home and Community-Based Long-Term Services and Supports (LTSS) Workers:



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☒ Home and Community-Based Long-Term Services and Supports (LTSS) Workers:

- * Program Role Category**
 - ☐ Schedulers.
 - ☐ Care Coordinators.
 - ☐ Functional Skills Trainers.
 - ☐ Case/Care Managers.
 - ☐ Community Health Workers.
 - ☐ Social Workers.
 - ☐ Supervisors.

*** D2. Please indicate the setting(s) the target workforce group(s) provide direct care in or select the service provided:**

- ☐ Short or Long-Term Outpatient, Community, School, or Home-Based Mental Health Treatment for Youth and Adults, including but not limited to: PACT for Youth, Adult, and Forensic Populations, FSS, ICS, Day Treatment, ACCS, Clubhouses, Respite, or Safe Havens
- ☐ Residential Mental Health,
- ☐ Vocational Rehabilitation Services,
- ☐ Habilitation and Rehabilitation Services,
- ☐ DPH-funded programs, including Syringe, Street Outreach, and Mobile Outreach Services, and Harm Reduction Drop-in Centers and Recovery Support Services,
- ☐ DCF-funded programs, including Comprehensive Foster Care and Support and Stabilization Services,
- ☐ Group Adult Foster Care and Adult Foster Care,
- ☐ Youth Intermediate-term Stabilization Services (known as Child/Adolescent Congregate Care Programs, including Residential Schools),
- ☐ In-home Basic Living Supports,

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☐ DCF-funded programs, including Comprehensive Foster Care and Support and Stabilization Services.

☐ Group Adult Foster Care and Adult Foster Care,

☐ Youth Intermediate-term Stabilization Services (known as Child/Adolescent Congregate Care Programs, including Residential Schools),

☐ In-home Basic Living Supports,

☐ Independent Living Centers,

☐ Home Health Services,

☐ Children's Behavioral Health Services,

☐ Home and Community-Based Services Waivers programs serving older adults, individuals with intellectual or developmental disabilities or Autism Spectrum Disorder, Acquired Brain Injury, Traumatic Brain Injury, Moving Forward, and Frail Elder,

☐ Continuous Skilled Nursing Services,

☐ Long-Term Services and Supports (LTSS) or Behavioral Health (BH) Community Partners (CPs),


☐ EOEA-funded home- and community- based programs,

☐ DDS-funded community-based programs,

☐ Substance Use Disorder Prevention, Intervention, Treatment, Recovery Support, Harm Reduction, or Co-Occurring SUD/MH services, in any of the following settings: community-based, home-based, school-based, outpatient, residential (eg. ATS, CSS, TSS)

*D3. Please estimate the total number of current and potential workers, or students impacted over the life of the proposed program

*D4. Describe the critical workforce need(s)/issue(s) that will be addressed through the program

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*E. Please describe the proposed program and program design. Please include a marketing and outreach plan, and outline the desired impact of the program related to pipeline development/recruitment, professional development/retention, or workforce-impacting information technology (IT). Please describe how the program will build, strengthen, and/or enhance efforts that promote workforce retention, recruitment, or training in Massachusetts:

Priority Criteria


*F4. Does the proposed program help diversify the workforce, with a focus on Black, Indigenous, and People of Color (BIPOC) staff and individuals with disabilities?

*G. Are you partnering with other organizations as part of your program?

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1. PROGRAM DESCRIPTION

*A. Program Name

*B. Program Type. Please select which of the following best describes your proposed program.

Pipeline Development and Recruitment Efforts

Professional Development and Retention Efforts

Workforce-Impacting Information Technology (IT) Improvements

* Program Subtype

☐ Partnerships/pilot programs with secondary/post-secondary institutions, including technical and vocational schools/high schools, to develop workforce pipeline programs such as paid internships and externships, and scholarships

☐ Initiatives to diversify the workforce, such as advertising/marketing open roles in multiple languages

☐ Initiatives that increase cultural/linguistic competence of workers to reflect the characteristics of the population served

☐ Funding internships, stipends, apprenticeships, preceptorships, fellowships, or related programs with a clear path to permanent employment

*C. Please indicate if this is a program expansion, or brand-new program.

Massachusetts State Seal

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program will build, strengthen, and/or enhance efforts that promote workforce retention, recruitment, or training in Massachusetts:

Priority Criteria

*F2. Does the proposed program expand existing educational capacity and create opportunities for students to enter the workforce post-graduation through partnerships with employers?



*F3. Does the proposed program support existing workforce with enhanced training/education opportunities that support career ladder advancements?

*F4. Does the proposed program help diversify the workforce, with a focus on Black, Indigenous, and People of Color (BIPOC) staff and individuals with disabilities?

*G. Are you partnering with other organizations as part of your program?

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1. PROGRAM DESCRIPTION

*A. Program Name

*B. Program Type. Please select which of the following best describes your proposed program.

- ☐ Pipeline Development and Recruitment Efforts
-  Professional Development and Retention Efforts
- ☐ Workforce-Impacting Information Technology (IT) Improvements

*Program Subtype

- ☐ Designing training or simulation labs that are linked to a path to employment
- ☐ Initiatives that create or increase participation in formal or informal on the job skills training (e.g., communication, English for Speakers of other Languages (ESOL), time management, soft skills, Medical Administration Program (MAP))
- ☐ Conversion of existing in person training to online training
- ☐ Expanding existing training into evening classes or multiple language offerings
- ☐ Educational advancement opportunities providing career ladders and a career pathway for the current and future workforce (e.g., HHA to CNA to LPN), including but not limited to tuition remission, certification, testing, and licensing fees.
- ☐ Offering wrap-around services for workers, such as case management, child-care vouchers, transportation assistance, technology purchases to ease situations that hinder scheduled assignments, education, or training, and bridges to a permanent solution.
- ☐ Funding innovation to support supervisors (mentorship, training, supervision time) and to significantly improve onboarding processes

*E. Please describe the proposed program and program design. Please include a marketing and outreach plan, and outline the desired impact of the program related to pipeline development/recruitment, professional development/retention, or workforce-impacting information technology (IT). Please describe how the program will build, strengthen, and/or enhance efforts that promote workforce retention, recruitment, or training in Massachusetts:

Priority Criteria

*F1. Does the proposed program create new or expand an existing regional workforce partnership to recruit, train or advance existing workers?

*F4. Does the proposed program help diversify the workforce, with a focus on Black, Indigenous, and People of Color (BIPOC) staff and individuals with disabilities?

*G. Are you partnering with other organizations as part of your program?

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*B. Program Type. Please select which of the following best describes your proposed program.

- Program Subtype

- *C. Please indicate if this is a program expansion, or brand-new program.

Clear

Expansion of a program

New program

• Program Role Category

- ☒ Care Coordinators.
- ☐ Companions.
- ☐ Developmental Specialists.
- ☐ Family Partners.

Priority Criteria

- *F1. Does the proposed program create new or expand an existing regional workforce partnership to recruit, train or advance existing workers?

*F2. Does the proposed program expand existing educational capacity and create opportunities for students to enter the workforce post-graduation through partnerships with employers?

- *F3. Does the proposed program support existing workforce with enhanced training/education opportunities that support career ladder advancements?


- * F4. Does the proposed program help diversify the workforce, with a focus on Black, Indigenous, and People of Color (BIPOC) staff and individuals with disabilities?

- * G. Are you partnering with other organizations as part of your program?

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tasks, and allow for more flexible staffing models

☐ Innovative uses of technology to communicate and provide additional clinical support for workers in community-based settings.

☐ Scheduling solutions to support flexibility and predictability in scheduling and allows for employees to choose their own shifts and swap shifts more easily

*C. Please indicate if this is a program expansion, or brand-new program.


If funds are requested to supplement an expansion of a program, awarded funding may not be used for the following purposes:

(1) as a duplication of benefits with funding awarded from another federal program.

(2) for programs and initiatives that overlap with CMS waiver extension proposals, or

(3) to supplant existing funding sources.

By completing this application, you acknowledge that you will not use these funds as outlined above. EHS reserves the right to request any additional documentation for verification.

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tasks, and allow for more flexible staffing models

☐ Innovative uses of technology to communicate and provide additional clinical support for workers in community-based settings.


☐ Scheduling solutions to support flexibility and predictability in scheduling and allows for employees to choose their own shifts and swap shifts more easily

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☐ Direct Care (DC) Staff: 

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*A. Please describe the implementation plan and timeline with key dates and milestones, including proposed duration of the program and applicable resources/level of effort needed to complete the program. The implementation plan must show that funds will be spent by March 1, 2025.

B. Please describe how the program and/or its impact can be sustained beyond the grant term (if at all):

*C. Please describe the staffing resources and level of effort that will be dedicated to implement the program (including project monitoring and oversight, coordination, reporting, and invoicing/budget management) and their qualifications:

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*D. Please identify and describe at least two metrics that will be collected to monitor the impact of the program and the process to gather, track and report on. Please detail how your proposed metrics will be measured and how they are relevant and significant to measuring your program's success.

For each of the reporting metrics, your organization will need to provide:

- A baseline report covering January 1, 2022 to June 30, 2022 that will be due prior to receipt of funds
- An initial report 6 months after receiving funds
- A final report at the conclusion of the program

*Metric 1


*Metric 2

E. Please provide any additional information that highlights and supports your capability to undertake the program:

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Add Partnerships

PARTNERS AND CONTACT INFORMATION
Please list the organizations and contact information for all partners. Any partnerships will need to submit, as part of the application, a corresponding letter of intent signed by all parties.

You may add rows as needed to represent your partnerships. Examples may include educational/academic institutions, training providers, other organizations, etc.


*A. Please describe the collaborative program and how it will work (e.g., one organization working with an educational institution):

*B. Please upload your partnership letter of intent:

Upload Files Or drop files

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Add Partnerships

PARTNERS AND CONTACT INFORMATION
Please list the organizations and contact information for all partners. Any partnerships will need to submit, as part of the application, a corresponding letter of intent signed by all parties.

You may add rows as needed to represent your partnerships. Examples may include educational/academic institutions, training providers, other organizations, etc.

*A. Please describe the collaborative program and how it will work (e.g., one organization working with an educational institution):

*B. Please upload your partnership letter of intent:


Upload Files Or drop files

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* Indicates required field

* Organization Type

* Organization Name

* Contact Name

* Title

* Phone

* Email

* Partner's Contribution/Role

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Add Partnerships

h, a corresponding letter of

viders, other organizations, etc.

t:

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* indicates required field

Total Implementation Funds Requested

Please fill in the Budget Request Narrative Form with all uses of funds. Additional rows can be added to accommodate additional activities and costs. Proposal submissions must show that the majority of the funds will be used to achieve the grant goals.


Add Program Cost

Total Budget Request : \$0.00

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Budget Details

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*Cost Category

*Activity

*Details / Justification

*Cost

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Please upload any additional supplemental materials and/or documentation that will support and bolster your application

[Upload Files](#) Or drop files

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As a condition of receiving funds, all grant recipients will be responsible for proposing a minimum of two program metrics and be responsible for recording and reporting on these proposed program metrics. Also as a condition of receiving funds, you may be asked to amend a proposed metric or report on additional metrics as communicated by the contracting entity in the award notification letter. These metrics will confirm your workforce initiative is on track to meet the goals outlined in your grant application.

You will be required to submit a report with your proposed program metrics after selection for a grant award and prior to grant funding.

Please note reporting cadence on proposed metrics will be:


- A baseline report covering January 1, 2022 to June 30, 2022 that will be due prior to receipt of funds
- An initial report 6 months after receiving funds
- A final report at the conclusion of the program

☐ *Please acknowledge that you are able to provide these metrics if awarded funds.

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* indicates required field

REQUIRED CERTIFICATIONS AND ACKNOWLEDGEMENTS

Indicate the Applicant's certification to, acknowledgement of, and agreement with, the statements below by checking the box associated with each statement. Please refer to the Request For Application (RFA) for the definition of capitalized terms used in this response.

A. ELIGIBLE ORGANIZATION

By submitting this response, the Applicant certifies that:


- ☐ "It is a Massachusetts provider of one of the services listed in Section 4.A.1 of the RFA, a Massachusetts education/training institution, a collaboration of multiple Massachusetts providers, a Massachusetts community-based organization, a Massachusetts private foundation, an owner of an existing workforce program, or a regional workforce or training partnership that benefits Massachusetts workers.
- ☐ "It will use any grant payment only for the purposes described in the Applicant's grant application, as awarded by EOHHS, and consistent with the requirements of the RFA. It will produce receipts or other evidence that funds were used as proposed and approved and will otherwise comply with the terms of the RFA and the Contract.
- ☐ "It is obligated to return to EOHHS the amount of any funding not used as proposed and approved, or otherwise in a manner that is inconsistent with the terms of the RFA and the Contract.

B. REQUIREMENTS FOR AWARDEES

If the Applicant receives an award under the Grant Program, it acknowledges and agrees that:

- ☐ "It will execute a Contract with EOHHS, or its designee, consisting of (listed in order of precedence):
 - The Commonwealth of Massachusetts Standard Contract Form.
 - The Commonwealth Terms and Conditions;
 - The contractual terms negotiated between EOHHS and the selected Awardee, including the additional contract terms set forth in Attachment C in the RFA;
 - EOHHS's RFA for Human Services, Home Health, and HCBS Workforce Development Grant Program, as it may be amended; and

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- EOHHS's RFA for Human Services, Home Health, and HCBS Workforce Development Grant Program, as it may be amended; and
- The Awardee's response to the RFA ("Proposal"), exclusive of any terms that are inconsistent with, or purport to modify or supersede, the Massachusetts Standard Contract Form, the Commonwealth Terms and Conditions, or the mandatory terms of the RFA.

☐ *It will abide by all terms and conditions set forth or incorporated in the Contract, including, without limitation:

- Restrictions on the use of funds;
- Reporting requirements; and
- Standard Contract Form Instructions, Contractor Certifications, and Commonwealth Terms and Conditions.

C. OTHER CERTIFICATIONS

The Applicant certifies that:

☐ *The information contained in this response is true and complete;

☐ *The response will remain in effect until a Contract resulting from this response is executed, or EOHHS otherwise notifies Applicant that it is not eligible under the RFA; and

☐ *This response is electronically signed by Applicant's authorized signatory.

APPLICANT SIGNATURE


*Organization Legal Name:

By:

*Name of Signatory:

*Title of Signatory:

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C. OTHER CERTIFICATIONS

The Applicant certifies that:

☐ *The information contained in this response is true and complete;

☐ *The response will remain in effect until a Contract resulting from this response is executed, or EOHHS otherwise notifies Applicant that it is not eligible under the RFA; and

☐ *This response is electronically signed by Applicant's authorized signatory.

APPLICANT SIGNATURE

*Organization Legal Name:

By:

*Name of Signatory:

*Title of Signatory:

Date:

09-29-2022

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