



Mental Health Scholarship Program One Year Residency (MHSP/OYR) at the Silberman School of Social Work at Hunter College



2017 Applicant Letter of Intent

The goal of the Mental Health Scholarship Program One Year Residency (MHSP/OYR) is to contribute to New York City’s community mental health services system by increasing the pool of skilled professionals employed in community-based agencies in contract with DOHMH by providing a tuition paid graduate social work education to employees that meet the requirements. The MHSP/OYR scholarship is available to 20 applicants that meet both DOHMH and OYR requirements in each calendar year.

Acceptance into this Program is contingent upon agency commitment to provide an educationally sound field placement, a certified field instructor and time off during work hours for the employee to attend classes during their field year. Given the requirements of the MHSP/OYR, it is crucial you discuss this with your agency leadership prior to applying.

Please Note: THIS IS NOT an application for the MHSP/OYR Program; this is a Letter of Intent for DOHMH. If you are deemed eligible, someone from DOHMH will contact you about the next steps.

Please complete the Eligibility Section to see if you meet eligibility for the Mental Health Scholarship Program.

NAME: _____

DATE: _____

A. Applicant Information

ELIGIBILITY

- a. Full-time employees who are working in an agency program that receives funds from The New York City Department of Health and Mental Hygiene’s Bureau of Mental Health (BMH) or the Bureau of Children, Youth and Families (CYF).

NOTE: It is not sufficient to be working in an agency that receives funds from NYC DOHMH, the employee must be working in a PROGRAM within the agency in contract with BMH or CYF.

- b. You are not eligible if you work in agency programs funded through the Bureaus of Alcohol & Drug Use Prevention, Care & Treatment or the Bureau of Developmental Disabilities, even if your agency also receives mental health funding.

1. Are you currently working full-time in an agency program in contract with BMH or CYF that provides mental health services or support to adults or children?

- Yes
No

If you selected “No,” then STOP. You are not eligible to apply. Otherwise, complete Question 2.

Please continue to next page



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2. Do you have a minimum of 2 years of full-time, paid employment in social work or social services, post-baccalaureate?

- Yes No

If you selected "No," then STOP. You are not eligible to apply. Otherwise, complete Question 3.

3. Which of the following is the primary target population that you work with in your program? (Select only ONE)

- Adults with Serious Mental Illness (SMI) Children, youth or young adults with serious emotional, behavioral or mental health challenges, and/or their families

4. Are you a legal resident of New York State?

- Yes No

If you selected "No," then STOP. You are not eligible to apply. Otherwise, complete Question 5.

5. The requirement of the Mental Health Scholarship Program is a commitment to remain working in your current agency program for 5 years (2 1/2 years during the OYR Program and 2 1/2 years post-graduation). If you are admitted into the MHSP, are you prepared to meet this requirement?

- Yes No

If you selected "No," then STOP. You are not eligible to apply. Otherwise, complete the rest of this form.

B. AGENCY AND PROGRAM INFORMATION

Please fill out this section for your current place of employment. Make sure all information is complete and legible. If not, your application will not be considered.

DOHMH Agency Contract #: Agency Name:

Program Name (where you work):

Program Address:

Your Work Title: Weekly # Hours working in program:

Work Phone: Work Email:

Your Supervisor's Name/Title:

Supervisor's Phone: Supervisor's Email:

Please continue to next page



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Indicate the type of program where you currently work (select only ONE item in Column a OR b):

a. Adult Programs:

b. Child, Youth and Family Programs:

- Assertive Community Treatment (ACT) Team
○ Case Management/Health Home
○ Clinic
○ Employment
○ Housing
○ Mobile Crisis
○ Outreach
○ Peer Advocacy / Self-Help
○ Psychosocial Club / Clubhouse
○ Recreation

- Home and Community Based Waiver
○ Family Support
○ Home Based Crisis Intervention
○ Mobile Response Teams
○ Vocational Program-Adolescent Skills Centers
○ Mobile Crisis
○ School based initiatives
○ Outreach programs
○ Children's Single Point of Access (CSPOA)
○ Specialized treatment models [i.e., Functional Family Therapy, and Intensive Crisis Stabilization and Treatment (ICST)]

C. DISCLAIMER AND SIGNATURE

This letter is to signify my intention to apply for the 2017 Mental Health Scholarship Program. I certify that my answers are true and complete to the best of my knowledge. Thank you for your consideration.

Sincerely,

Name (Signature): _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Personal Email: _____

This form must be received no later than January 6, 2017. If it is received after this date, it will not be considered. Scan and Email this form to:

Marlene Mendelson, LCSW at mmendelson@health.nyc.gov

For Office Use Only:

Empty rectangular box for office use.