New York City Department of Health & Mental Hygiene (DOHMH)

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

2016 Applicant Letter of Intent

Please complete Section A to see if you are eligible to apply. Please note: This is not an application; it is a Letter of Intent. If you are deemed eligible, you will be contacted about the next steps.

DATE:______________________

A. ELIGIBILITY QUESTIONS
(Applicant must be a full-time employee in an agency program providing mental health services in contract with the New York City Department of Health and Mental Hygiene’s Bureau of Mental Health (BMH) or Bureau of Children, Youth and Families (CYF). Individuals who work in programs that only have contracts with the Bureau of Alcohol & Drug Use Prevention, Care & Treatment, or the Bureau of Developmental Disabilities, are NOT ELIGIBLE for this scholarship.)

1. Are you currently working full-time in an agency program that provides mental health services to adults or children that is in contract with the Bureau of Mental Health or the Bureau of Children, Youth and Families? (Ask your Supervisor how to find this information for your program.)
   ○ Yes
   ○ No
   **If you selected “No,” then STOP. You are not eligible to apply. Otherwise, complete Question 2.**

2. Do you have 2 years of full-time, post-baccalaureate social work experience in a social service institution?
   ○ 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. If you are admitted into the Mental Health Scholarship Program, are you prepared to remain working in your current agency program for 5 years (2½ years during the OYR Program and 2½ years post-graduation)?
   ○ 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. Ask your Supervisor how to find the information in this section. If this section is not COMPLETELY filled out, your application will not be considered.

DOHMH Agency Contract #:_____(usually 3-4 numbers) Agency Name:_________________________________________

Program Name (where you work):____________________________________________________________________

Program Address:_________________________________________________________________________________

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

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

b. Child, Youth and Family Programs:
   - 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)]

Your Work Title:___________________________________________ Weekly # Hours spent working in program:_____

Work Phone:________________ Work Fax:________________ Work Email:______________________________

Your Supervisor’s Name/Title:____________________________________________________________________

Supervisor’s Phone:________________ Supervisor’s Email:_________________________________________

C. DISCLAIMER AND SIGNATURE
Dear SSSW at Hunter College Application Committee,

This letter is to signify my intention to apply for the 2016 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 (Print Last Name, First Name):_________________________________________________________________

Home Address:___________________________________________________________________________________

Home Phone:____________ Cell Phone:____________ Home Email:_______________________________________

This form must be received no later than February 15, 2016. Email this form to:
Marlene Mendelson, LCSW at mmendelson@health.nyc.gov

For Office Use Only: