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**DIRECT CARE WORKFORCE INNOVATION PROGRAM APPLICATION**

* Please complete all fields of the application.
* Applicants may include Letters of Support as an attachment to the application.
* Applications must be submitted to [dlwdaldcwip-labor@maryland.gov](mailto:dlwdaldcwip-labor@maryland.gov) by **5:00 pm on July 1, 2022**. Applications received after this time will not be considered.

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| **APPLICANT INFORMATION** | |
| **Organization Name:** |  |
| **Employer Identification Number (An EIN is written in the form 00-0000000):** |  |
| **Organization Phone Number:** |  |
| **Organization Street Address (City, State, Zip code):** |  |
| **Point of Contact Name:** |  |
| **Point of Contact Email Address:** |  |
| **PROJECT OVERVIEW** | |
| 1. **Indicate the amount of funds requested, up to a maximum amount of $50,000.** | |
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| 1. **Indicate the number of individuals that will be served, should your proposal be granted funding.** | |
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| **APPLICANT AND PARTNER EXPERIENCE** | |
| 1. **Provide a brief profile of the applying organization, highlighting any previous experience related to recruiting or providing training to direct care workers. If none, please state N/A.** | |
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| 1. **Provide a brief profile and describe the role any of the following institutions will play in the project:**  * **Institutions of Higher Education;** * **Maryland Department of Health;** * **Maryland Board of Nursing;** * **Maryland Higher Education Commission;** * **American Job Centers; or** * **Organizations with expertise in the needs of women, racial minorities, or immigrants, and the impoverished.** | |
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| 1. **Provide a brief profile of all other partner organizations and describe their role in the project.** | |
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| **DESCRIPTION OF PROPOSED USE OF FUNDING (PROJECT PLAN)** | |
| 1. **Describe your organization’s proposed plan for the use of funding.** | |
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| 1. **Include a description of current or projected job openings, or relevant Labor Market Information related to direct care workers in the region to be served by the project.** | |
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| 1. **Describe the geographic scope of the workforce to be served by the project.** | |
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| 1. **Describe specific efforts or strategies that the project will undertake to reduce barriers to the recruitment, retention, or advancement of direct care workers. Applicants should list all innovative models or processes the organization will implement to support the retention of direct care workers.** | |
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| 1. **Describe any supportive services and benefits that will be provided to participants and explain how this will support retention.** | |
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| 1. **How will the applicant make use of career planning to support the identification of advancement opportunities and career pathways for direct care workers that will be served by the project?** | |
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| 1. **Describe how the applicant will collect and submit required data outcomes outlined in the *Direct Care Workforce Innovation Program* policy.** | |
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| 1. **Describe how the applicant will consult with direct care workers, representatives of direct care workers, and the families of individuals assisted by direct care workers throughout the project.** | |
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| 1. **Describe how the applicant will inform participants about their rights as direct care workers.** | |
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| 1. **How will participants be recruited for training? Are there target groups identified, and how will the project ensure the target population is reached? See page 8 of the *Direct Care Workforce Innovation Program* policy for information on targeted populations for this grant funding.** | |
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| 1. **How will the organization assess the satisfaction of trainees and participating employers?** | |
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| **OVERVIEW OF PROGRAM COSTS** | |
| 1. **Provide an itemized list of ALL costs associated with your project proposal that will be funded by Labor. This list must match the amount of funds requested.** | |
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| 1. **To receive funding, the applying organization shall secure contributions (cash or in-kind) at least equal in value to the amount of funding requested. Please list the amount of the match and provide documentation to substantiate the contribution. This may be included as an appendix to the application.** | |
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| 1. **List and quantify any leveraged resources that are not already included in the matched funding above. Please insert N/A if there are none.** | |
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| **TIMELINE OF PROJECT** | |
| 1. **Describe the estimated timeline for all project’s key activities. Grants will begin on October 1, 2022.** | |
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| **OVERVIEW OF THE PROJECT DELIVERABLES** | |
| 1. **Please fill out the below chart and include a description of how the activities proposed by the organization will successfully achieve the deliverable.** | |
| **Number of individuals recruited** |  |
| **Number of individuals to attain employment as a direct care worker** |  |
| **Number of individuals or families assisted by direct care workers via the program** |  |
| **Services, benefits, or support provided to assist in the recruitment, retention, or advancement of direct care worker participants and the number of individuals who accessed them** |  |
| **Performance Indicators** | |
| **Number of individuals placed into unsubsidized employment** |  |
| **Median earnings second quarter after exit** |  |
| **Number of individuals to obtain an industry-recognized certification or credential** |  |
| **Number of individuals to achieve a measurable skills gains\*** |  |
| **Employment Retention Data** | |
| **Retention rate 6 months after entering employment** |  |
| **Retention rate 12 months after entering employment** |  |
| **Description of how the organization will track this data:** | |
| **OTHER** | |
| 1. **When funds awarded under the grant are exhausted or the project has ended, how will the efforts initiated under your proposal be sustained?** | |
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| 1. **Provide a description of how this proposal supports the innovation of Maryland’s response to improving training and retention efforts for direct care workers.** | |
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| **AFFIRMATION** | |
| 1. **On behalf of INSERT ORGANIZATION NAME I affirm that INSERT ORGANIZATION NAME is not under investigation by an federal, State, or local government entity for alleged criminal or civil violations of laws or regulation enforced by these entities. Affirm** | |
| **Yes**  **No** | |
| 1. **On behalf of INSERT ORGANIZATION NAME I affirm that there shall be no cost to direct care workers or individuals assisted by direct care workers for receiving any benefits or services provided under the project.** | |
| **Yes**  **No** | |

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| **APPLICANT SIGNATURE:** |  |
| **DATE:** |  |

**\*For more information on what is considered a “measurable skills gain,” please visit https://www.dol.gov/agencies/eta/performance/performance-indicators.**