ATTACHMENT 2

Program Specific Questions

Solicitation of Interest #20283

Nurses Across New York Loan Repayment Program– Cycle I

Instructions: Respond to each of the questions in all sections described below when completing the Program Specific Questions. *All questions* require an answer, and you must ensure all answers are legible. Applicants are instructed to upload the completed document as Attachment 2 of the application.

Part 1: Applicant Identification

The questions in this section refer to the individual who is applying for the NANY grant (i.e. the Applicant). The Department of Health will be contracting with this entity.

1a. Name of Applicant: _____

1b. Address of Applicant: _____

_____

If the Applicant is a facility, provide contact information of the person responsible for the submission. If the applicant is an individual nurse, enter the contact information for that nurse.

1c. Name of Contact Person:_____

1d. Phone of Contact Person: _____

1e. Email of Contact Person: _____

1f. Status of Applicant (circle one): Not-for-Profit For-Profit

(*If you are an individual nurse applicant, you should select "For Profit*")

Indicate the type of Applicant. The nurse named above must match the type of Applicant selected below [i.e. a nurse is an individual applicant or (1g). A Health Care Facility Applicant is either (1h), (1i), (1j) or (1k)]. **You are not eligible unless you can answer "Yes" to ONE of the following (5) options**. **Do not select more than ONE option.**

1g. Are you an individual Nurse Applicant?

YES NO

1h. Are you a Health Care Facility Applicant operating as a general hospital, D&TC, or a nursing home licensed by the Department of Health pursuant to PHL Article 28?

YES NO

1i. Are you a Health Care Facility Applicant certified, or operated, by the Office of Mental Health pursuant to MHL Article 31?

YES NO

1j. Are you a Health Care Facility Applicant certified, or operated, by the Office of Alcoholism and Substance Abuse Services pursuant to MHL Article 32?

YES NO

1k. Are you a Health Care Facility Applicant operating as a medical practice that is registered with the New York State Department of State as a Professional Corporation (PC) or a Professional Limited Liability Corporation (PLLC) at the time of application?

YES NO

Part 2: Nurse Identification

The questions in this section refer to the nurse applicant who will be completing the NANY service obligation.

2a. Nurse Applicant Name: _____

2b. Nurse Applicant Title (circle one): RN LPN

2c. Nurse Applicant Mailing Address: _____

_____

2d. Nurse Applicant Phone: _____

2e. Nurse Applicant Email: _____

Part 3: Facility Identification

The questions in this section refer to the primary facility where the nurse will be practicing when fulfilling their NANY service obligation. One hundred percent of the applicant's time must be accounted for at all sites combined.

3a. How many different facilities will the Applicant be practicing in while fulfilling their NANY service obligation (circle one)?

One Two Three Other: _____

3b. Primary Facility Name: _____

3c. Primary Facility Address: _____

_____

3d. County of Primary Facility: _____

3e. Primary Facility Region (circle one): NYC Rest of State

3f. Identify Primary Facility by Type (check one):

_____ Federally Qualified Health Center
_____ Health Care Agencies
_____ Adult Care Facilities
_____ Private Practice
_____ Hospital
_____ Nursing Home
_____ Other: _____

3g. Primary Facility New York State DOH, OASAS, or OHM Operating Certificate # or Department of State Identification #. This number can be obtained from your employers Administrative Office.

_____

3h. Percent of time spent at Primary Facility: _____

3i. Is Primary Facility in a HPSA (circle one): Yes No

3j. If yes, provide the HPSA number: _____

If there is more than one facility, fill out Attachment 10 with information on subsequent facility(ies). Then upload Attachment 10 as part of the application.

Part 4: Use of Funds

4a. Identify what the NANY funds will be used for (check one):

_____ Nurse Applicant to repay outstanding qualified educational debt

_____ A Health Care Facility to retain or recruit applicants

4b. State the total amount for funding you are requesting for this NANY application (not to exceed the maximum of 10,000 for LPN's or $25,000 for RN's for three years).

$_____ Total request for three years

Part 5: Nurse Applicant Current Status

5a. Is the nurse applicant currently licensed to practice as a nurse in New York State?

If yes, provide license number or provide the date that you applied for your license in New York State.

YES: _____ NO: _____

NYS License #: _____ Application Date: _____

5b. What is the nurse's start date for his/her employment contract submitted with this application? Provide that start date in the format of (mm/dd/yy).

_____

Part 6: Other Scholarships, Loan Forgiveness, Etc.

A nurse named in the application cannot be fulfilling a public or private obligation under any local, state or federal government loan repayment program (except the Public Service Loan Forgiveness Program) which overlaps or coincides with the three-year NANY obligation period. Nurses receiving employer sponsored loan repayment funds are eligible to apply.

6a. Has the nurse named in this application received any loan repayment program funds including those listed above? If yes, please specify name of program, amounts, and dates of service obligation (mm/dd/yy).

YES NO

Amount: _____

Date: _____

6b. Has the nurse named in this application applied for any scholarships, loan forgiveness, or other funds which are pending a decision? If yes, name the program and when the applicant will be notified of their award status (mm/dd/yy).

YES NO

Amount: _____

Date: _____