Healthcare Training Scholarships

Deadline – August 15, 2024

Completed applications can be submitted via email to [cpeworkforce@ky.gov](mailto:cpeworkforce@ky.gov).

**Required attachment:**

Upon proposal submission, please attach a copy of the total proposed budget for the program. The budget needs to include the healthcare partner contribution and the amount of healthcare workforce investment funds requested for match.

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**Identify the participating healthcare program.**

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**Identify the participating healthcare partner(s).**

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**How many employees does the healthcare partner(s) have?**

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**Please provide the amount of funds requested for match.**

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**How does the healthcare program plan to use the healthcare partner’s contribution and match from the fund to award healthcare training scholarships in the eligible healthcare credential?**

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**How will the healthcare program increase student enrollment in the**

**eligible healthcare credential, program completion, and meet local, regional, or state workforce demands? In your response, identify strategies that will be used.**

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**What is the healthcare program's plan for student recruitment, the scholarship award criteria, and the selection process? In your response, identify any strategies that will be used during these processes.**

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**How will the healthcare partner onboard and retain graduates? In your response, identify any strategies that will be used.**

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**How will graduates be supported through their service obligations? In your response, identify any strategies that will be used.**

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**How will this partnership improve diversity within the specific healthcare credential and/or plan to address the specific needs of a historically underserved county or region? In your response, identify strategies that will be used.**

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**Optional: Please provide any additional details on how this partnership will serve the priorities set forth in KRS 163.0403.**

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**Identify the designated points of contact for both the healthcare program and healthcare partner(s).**

**Healthcare Program**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Healthcare Partner**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If there are multiple healthcare partners, please use the additional space below.*

**Healthcare Partner**

Full name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Required Signatures**

By signing this proposal, you are acknowledging that the statutory requirements shall be satisfied as set forth in KRS 164.0403.

Chief Executive Officer - Healthcare Program Date

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Chief Executive Officer - Healthcare Partner Date

*If there are multiple healthcare partners, please use the additional signature line below.*

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Chief Executive Officer - Healthcare Partner Date

By signing this proposal, you are certifying the contribution outlined in the budget.

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Chief Financial Officer - Healthcare Partner Date