



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

2023 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.

This is the Letter of Intent – detailed information regarding the program and agency commitment is in the Admissions material. Please review those materials carefully.

Please Note: THIS IS NOT an application for the MHSP/OYR Program; this is a Letter of Intent for DOHMH. This is the first step in the process of applying for the DOHMH Mental Health Scholarship Program. If you are deemed eligible, DOHMH will contact you about the next steps. If you are eligible to continue, you will submit your APPLICATION to the Silberman School of Social Work OYR Program, DOHMH Mental Health Scholarship. If your APPLICATION moves to the next step in the process, you will be contacted about a GROUP INTERVIEW.

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

NAME: _____

DATE: _____

A. Applicant Information

ELIGIBILITY

Full-time employees who are working in an agency that has at least one contract with 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). Additional eligibility requirements are listed below.

1. Are you currently working full-time in an agency with at least one 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.

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

- 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 for 4 - 4 1/2 (2 - 2½ years during the OYR Program and 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.

Agency Name:

Program Name (where you work):

Program Address:

Program Type: _____

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

Work Phone: _____

Work Email: _____

Your Supervisor's Name/Title: _____

Supervisor's Phone: _____ Supervisor's Email: _____

C. DISCLAIMER AND SIGNATURE

This letter is to signify my intention to apply for the 2023 Mental Health Scholarship Program. I certify that my answers are true and complete to the best of my knowledge. Thank you for your consideration.

Name (Signature): _____

Home Address: _____

Home Phone: _____ Cell Phone: _____

Personal Email: _____

This form must be received no later than January 6, 2023 at 5:00 pm. If it is received after this time, it will not be considered. Scan/Email this form to:

Novelett Massey at nmassey@health.nyc.gov AND Marlene Mendelson, LCSW at mmendelson@health.nyc.gov

Please type "DOHMH Mental Health Scholarship Program" in the Subject Line of the email.

For Office Use Only: