This application is for organizations seeking funding from the Maryland Department of Labor under the Direct Care Workforce Innovation Program. Please complete all fields of this application and submit with the other required documentation by **11:59 PM on April 4, 2025. Completed applications should be submitted via email to Casey Tiefenwerth at casey.tiefenwerth1@maryland.gov. Submissions must include all required documents listed below and should be submitted as one PDF file in a single email. In addition, the Program Budget should also be submitted as an Excel sheet (.xlsx).**

Prior to submission, review the required and optional documents table below to ensure a complete application. Applicants are also encouraged to carefully review the [Direct Care Workforce Innovation Program policy](https://labor.maryland.gov/employment/mpi/) prior to completing this application.

**Direct Care Workforce Innovation Program Application Submission Checklist**

Applicants that are Direct Care employers must provide a letter from any partners with whom they will be working. If the applicant is not working with any partners, no letters of support are required.

Applicants that are non-profits (excluding non-profits that are applying as Direct Care employers), labor organizations, and/or entities with shared labor-management oversight must also provide at least two letters of support and/or Memorandum of Understandings from employer or industry partners.

|  |  |
| --- | --- |
| **REQUIRED DOCUMENTS** | **OPTIONAL DOCUMENTS** |
| * **Direct Care Workforce Innovation Grant Application**
 | * **Additional Letter(s) of Support**
 |
| * **Direct Care Workforce Innovation Program Budget (.xlsx)**
 | * **Sample Program Curriculum**
 |
| * **Required Match Documentation**
 | * **Special Promotional Materials**
 |
| * **Letter of Support (1)**
 |  |
| * **Letter of Support (2)**
 |  |
| * **Signed W9 Form**
 |  |
| * **Certificate of Good Standing**
 |  |

|  |
| --- |
| **SECTION 1: APPLICANT INFORMATION** |
| **1** | **Organization Name** |  |
| **2** | **Employer Identification Number (FEIN)** |  |
| **3** | **Point of Contact Name** |  |
| **4** | **Point of Contact Title** |  |
| **5** | **Point of Contact Email Address** |  |
| **6** | **Point of contact Phone Number** |  |
|  **7** | **Organization Street Address** |  |
|  |
|  |

|  |
| --- |
| **SECTION 2: APPLICANT AND PARTNER PROFILES & PROGRAM EXPERIENCE** |
| **8** | **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.**  |
|  |
| **9** | **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.
 |
|  |
| **10** | **Provide a brief profile of all other partner organizations and describe their role in the project.**  |
|  |

|  |
| --- |
| **SECTION 3: DESCRIPTION OF PROPOSED USE OF FUNDING (PROJECT PLAN)** |
| **11** | **Describe your organization’s proposed plan for the use of funding.**  |
|  |
| **12** | **Provide information on current or projected job openings or relevant Labor Market Information related to direct care workers in the region to be served by the project.** |
|  |
| **13** | **Describe the geographic scope of the workforce to be served by the project** |
|  |
| **14** | **How will applicants 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.*  |
|  |
| **15** | **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.* |
|  |
| **16** | **Describe any supportive services and benefits that will be provided to participants and explain how this will support retention.** |
|  |
| **17** | **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?**  |
|  |
| **18** | **Describe how the applicant will collect and submit required data outcomes outlined in the Direct Care Workforce Innovation Program policy.**  |
|  |
| **19** | **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.** |
|  |
| **20** | **Describe how the applicant will inform participants about their rights as direct care workers.**  |
|  |
| **21** | **How will the organization assess the satisfaction of trainees and participating employers?** |
|  |
| **22** | **Describe the estimated timeline for all project’s key activities.** *Grants will begin on June 1, 2025 and end on May 31, 2028. Applicants are not required to write a budget for the entire three-year period.* |
|  |
| **23** | **When funds awarded under the grant are exhausted or the project has ended, how will the efforts initiated under your proposal be sustained?**  |
|  |
| **24** | **Provide a description of how this proposal supports the innovation of Maryland’s response to improving training and retention efforts for direct care workers.** |
|  |

|  |
| --- |
| **SECTION 4: PROGRAM EVALUATION AND REPORTING TARGETS** |
| **25** | **Complete the chart below to identify the program’s targeted key performance outcomes.**  |
| **A** | There are **five eligible training occupations** under the Direct Care Workforce Innovation Program. Please select which of the following roles individuals who complete training will be prepared for. |
| [ ]  Certified Nursing Assistant/Geriatric Nursing Assistant[ ]  Home Health Aide[ ]  Nursing Assistant[ ]  Personal Aide[ ]  Psychiatric Aide |
| **B** | Number of individuals recruited to be employed as direct care workers. |  |
| **C** | Number of individuals served by the program. |  |
| **D** | Number of individuals to attain unsubsidized employment as a direct care worker. |  |
| **E** | Number of individuals or families assisted by direct care workers via the program.  |  |
| **F** | Median earnings (in dollars) second quarter after exit. |  |
| **G** | Number of individuals to obtain an industry-recognized certification or credential. |  |
| **H** | Number of individuals to achieve a measurable skills gain\*.*\* "Measurable Skills Gain” is a workforce performance indicator defined* *by the* [*US Department of Labor*](https://www.dol.gov/agencies/eta/performance/performance-indicators)*.* |  |
| **I** | Retention rate 6 months after entering employment. |  |
| **J** | Retention rate 12 months after entering employment. |  |
| **26** | **Describe how the applicant will track and evaluate each of the performance outcomes identified above in questions B-J**. **Specify how the applicant will evaluate participant and employer satisfaction with programming.** |
|  |
| **27** | **Describe any 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.**  |
|  |

**Instructions for Section 5: Program Financial Information**

Complete this section for the Direct Care Workforce Innovation Program grant requested. Information in this section **must** be consistent with the itemized Direct Care Workforce Innovation Budget provided with the application. The Program Budget should be completed and submitted as an Excel document (.xlsx) along with this application. Please reconcile Section 5 of this application with the associated Program Budget prior to submission.

**Commitment of non-State Matching Funds**

The Direct Care Workforce Innovation requires that applicants can demonstrate a dollar-for-dollar (100%) match of the requested grant amount. Matching funds may be either monetary or in-kind. Applicants must clearly identify all additional leveraged resources in the itemized Direct Care Workforce Innovation Budget and include the total amount in Question C from Section 5 of this application. Review these items prior to submitting this application.

|  |
| --- |
| **SECTION 5: PROGRAM FINANCIAL INFORMATION** |
| **28** | **Provide the following financial information about the funding requested.** |
| **A** | Total grant amount requested | $ |
| **B** | Amount of matched funding | $ |
| **C** | Amount of any other leveraged resources (beyond the match)  | $ |
| **D** | Grantees have upto three years to spend funds awarded from the Direct Care Workforce Innovation Program. Please indicate the requested period of performance for the grant (for instance, six months, one year, etc.). |  |

**Applicant Affirmations and Submission**

Prior to signing below, review all sections of this application for completion and accuracy. Review the [Direct Care Workforce Innovation Program Policy](https://labor.maryland.gov/employment/mpi/mpi10-22.pdf) for any additional requirements associated with this program. Ensure that all required attachments and any desired optional attachments are included in the final submission.

|  |  |
| --- | --- |
|  | **AFFIRMED** |
| The undersigned affirms that the applicant organization is in good standing with the Comptroller of Maryland and the Maryland Department of Labor. |

|  |
| --- |
|  |

 |
| The undersigned affirms that the contents of this application are true, verifiable, and in compliance with all requirements put forth in the program policy. |

|  |
| --- |
|  |

 |

|  |  |
| --- | --- |
| **Applicant Full Name** |  |
| **Applicant Title** |  |
| **Applicant Email** |  |
| **Applicant Phone Number** |  |

|  |  |
| --- | --- |
| **Applicant Signature** | **Date** |
|  |  |
|  |