Healthcare Training Scholarships

**Deadline – April 30, 2025**

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

**Under KRS 164.0401, the credential/licensure areas listed in the drop-down box qualify for HWIF funding. From the drop-down box, please select the credential/licensure area that applies to your program.** Choose an item.

**Identify the participating healthcare program. Include institution name, program name, and degree/credential level.**

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

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*Please note: The following sections of the application should be jointly completed by the healthcare program and healthcare partner.*

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

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| **Proposed Budget** | |
| **Healthcare Partner Contribution** | **$\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Requested HWIF Match** | **$\_\_\_\_\_\_\_\_\_\_\_\_\_** |
|  | |
| **Full-Tuition Cost**  ***(per student, per year)*** |  |
| **# of Students Receiving**  **Full-Tuition Scholarships**  ***(breakdown by academic year)*** |  |
| **Scholarship Award Amount**  ***(per student)*** |  |
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| *KRS 164.0403 - Each recipient of a scholarship will be required to practice as a licensed or certified medical professional in the Commonwealth for a contract period of one (1) year for each academic year funded by the scholarship up to a maximum of two (2) total years.*  *Unless the partnership is with a state registered nursing aid training program, the healthcare partner can place a restriction for the scholarship recipient(s) to work for them upon graduation for the contracted period noted above.* | |
| **Will the healthcare partner be requiring the student(s) to work for them upon graduation for the contract period identified above?** |  |

**Supply/Demand of Credential**

**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? (400-word limit)**

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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.**

**(400-word limit)**

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**Addressing the Unique Needs of a Historically Underserved County or Region**

**How will this partnership address the unique needs of a historically underserved county or region? In your response, use labor market data and student completion data to support your justification. (250-word limit)**

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**Dedication to Student Success**

**What is the healthcare program's plan for student recruitment, the scholarship award criteria, and the selection process? In your response, identify specific strategies that will be used during these processes. (250-word limit)**

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**How will the healthcare partner onboard and retain graduates? In your**

**response, identify any strategies that will be used. (250-word limit)**

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**How will graduates be supported through their service obligations? In your response, identify any strategies that will be used. (250-word limit)**

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**Optional: Please provide any additional details on how this partnership will serve the priorities set forth in KRS 163.0403. (250-word limit)**

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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