

BEHAVIORAL HEALTH STIPEND PROGRAM APPLICATION

APPLICANT INFORMATION			
Full Name		Date of Birth	
Address			
Gender	Social Security #	Ethnicity	City and State of Birth
Personal Phone		Personal Email	
EDUCATION			
Name of School	City/State	Graduation Date	Degree
Name of School	City/State	Graduation Date	Degree
EDUCATIONAL DEBT INFORMATION			
Original Total Loan Amount		Current Total Loan Amount	
LICENSURE AND REGISTRATION			
<p>I have a pre-licensure registration issued by the Board of Behavioral Sciences (BBS) for:</p> <p><input type="checkbox"/> Associate Marriage and Family Therapist (AMFT)</p> <p><input type="checkbox"/> Associate Clinical Social Worker (ACSW)</p>			
<p>I am licensed by the Board of Behavioral Sciences (BBS) for:</p> <p><input type="checkbox"/> Licensed Marriage and Family Therapist (LMFT)</p> <p><input type="checkbox"/> Licensed Clinical Social Worker (LCSW)</p>			
Temp MSP Number (AMFT or ACSW):		Board of Behavioral Sciences (BBS) Licensure Number (LMFT or LCSW):	
BBS Registration / License Expiration Date:		BBS Registration / License Status:	
		<input type="checkbox"/> Active <input type="checkbox"/> Not Currently Active	

LANGUAGE

Are you fluent in a language or languages other than English, including sign language?

Yes — please indicate language(s):

No

If you indicated Spanish in the previous question, please mark your level of fluency:

Fluent

Conversational

Medical Spanish

EMPLOYMENT INFORMATION

Name

Corporate Address

Suite/Floor

City

State

Zip Code

Work Phone

Work Email

Date of Hire

Annual Salary

HUMAN RESOURCES REPRESENTATIVE

Name

Title

Address (including suite/floor)

City

State

Zip Code

Work Email

Work Phone

PRACTICE SITE INFORMATION

Are you committed to serving in your current practice site for at least two (2) years?

- Yes
- No

Please indicate the type of your practice site (check one):

- Federally Qualified Health Center (FQHC)
- FQHC Look-Alike
- County Behavioral Health Agency

Do you primarily serve Medi-Cal, uninsured, or low-income clients?

- Yes
- No

If you will work at more than one (1) practice site, please provide the following information for all individual practice sites below.

IMPORTANT NOTE: Each suite/floor is considered a practice site

Practice Site #1

Employer Name		Number of hours working at this site each week	
Site Address			Suite/Floor
City	State	Zip Code	County
Site Phone Number			
Supervisor Name		Title	

Practice Site #2

Employer Name		Number of hours working at this site each week	
Site Address			Suite/Floor
City	State	Zip Code	County

Supervisor Name	Title
ASSOCIATES (AMFT OR ACSW)	
Are you committed to attaining 2,000 hours of supervision toward your licensure within two (2) years?	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
How many supervision hours toward licensure have you completed to date?	
What is your average number of supervised hours per week?	
At which clinic or organization are you currently receiving supervision?	
Supervising Clinician Information	
<i>Your supervising clinician must hold a current BBS license (LMFT or LCSW) compatible with your registration type and must be affiliated with your approved placement site.</i>	
Supervising Clinician Full Name	BBS License Number
License Type (LMFT or LCSW)	
Supervising Clinician Work Email	Supervising Clinician Work Phone
Supervising Clinician Practice Site / Organization	
LICENSED (LMFT OR LCSW)	
Are you committed to providing supervision to AMFT/ACSW associates for a minimum of the following units within two (2) years? Please select your minimum commitment:	
<input type="checkbox"/> 208 units (approximately 4 units per week) <input type="checkbox"/> 416 units (approximately 8 units per week)	
How many associates are you currently supervising?	
How many units are you currently providing?	
What practice site are you conducting the supervision for?	

Supervisee Information

List all current associate supervisees. Each supervisee's registration type must be compatible with your BBS license type.

Supervisee Full Name	BBS Registration # (AMFT or ACSW)	Registration Type

PERSONAL STATEMENT (*Personal statement may also be submitted as an attachment.*)

Please describe how you have demonstrated cultural sensitivity to your patient communities, a long-term interest in providing access to quality health care for vulnerable and low-income individuals and families, and leadership potential in the community health field.

Supplemental Questions (*Supplemental questions may also be submitted as an attachment.*)

1. Were you born or raised in Riverside or San Bernardino County? If so, could you share a bit about your upbringing and your connection to the area?
2. Do you plan to continue living and working in Riverside or San Bernardino County in the coming years? If so, what motivates this decision?
3. How do you see yourself contributing to the Inland Empire community in the future?

REQUIRED DOCUMENTS

Please turn in all the following documents when submitting the application:

- Temp MSP or Licensure from BBS Certification
- CV or Resume
- Disadvantaged Background Attestation

Associates (AMFT / ACSW) only:

- Supervising Clinician BBS License Verification

Licensed Clinicians / Supervisors (LMFT / LCSW) only:

- BBS Supervision Agreement

AUTHORIZATIONS AND ACKNOWLEDGMENTS

BBS Weekly Hours Log Authorization:

By signing this application, I authorize the Program Administrator to access and review my BBS weekly hour logs and copies of my supervisees' BBS weekly hour logs, for the purpose of verifying compliance with program eligibility and hour/unit requirements.

Repayment Clause Acknowledgment:

I understand that this program provides a conditional stipend award subject to a repayment clause. My right to retain stipend funds is contingent on satisfying all service and compliance conditions described in the Stipend Agreement. Failure to complete the program term or meet applicable milestones may result in a pro-rated repayment obligation. I have been encouraged to seek independent legal advice before signing the Stipend Agreement.

I have read and understand the repayment clause described above.

SUBMISSION PROCESS: Submit all materials via mail or email to Program Administrator

<p><u>MAIL</u> Uncommon Good 211 W. Foothill Blvd. Claremont, CA 91711 Attention: Eric Santizo</p>	<p><u>EMAIL</u> esantizo@uncommongood.org Subject Line: Applicant's Name, BHSP Attention: Eric Santizo</p>
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APPLICANT SIGNATURE DISCLAIMER

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in my application being dismissed or my award withdrawn.

Print and Sign Completed Application.

Applicant Signature	Completion Date
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