**Vermont Nurse Preceptor Incentive Grants Program**

**Cover Page**

**Applicant Information**

Business Legal Name:

DBA *(Doing Business As):*

Unique Entity Identifier (from SAM.Gov):

**Contact Information**

* **Primary Contact Person**

Application Contact #1 First and Last Name:

Title:

Role at Applicant Organization:

Business Email Address:

Business Phone Number:

* **Secondary Contact Person**

Application Contact #2 First and Last Name:

Title:

Role at Applicant Organization:

Business Email Address:

Business Phone Number:

**Grant Request Summary**

Please ensure that the amounts provided here match the amounts identified in the Budget Form submitted as part of this application.

**Grant Period: July 1, 2023 – June 30, 2024:**

Total Funds Requested:

Total Matching Funds, if any:

Note: Matching funds may be used for any or all of the following purposes:

* Increase the per preceptor hour rate of Incentive Pay paid to nurse preceptors;
* Expand the number of nurse preceptors receiving Incentive Pay; and
* Extend the duration of Incentive Pay beyond the Program time frame.

**Grant Period: July 1, 2024 – September 30, 2026**

Would your organization like to be considered for additional grant funds to support preceptor incentive pay for nurse preceptors in this grant period?

[ ]  Yes [ ]  No

If yes, do you anticipate that your organization will be able to commit to providing future compensation (e.g., matching funds) and support to expanding the number of preceptors?

[ ]  Yes [ ]  No

If yes, please briefly describe the type of future compensation and support your organization would provide**.** (Max. 350 words):

**Authorized Signature**

Signature:

Name:

Title:

Date:

Email address:

Phone number:

**Grant Application Questions**

1. **Please provide a brief summary of your organization’s mission and scope of services.** Please be sure to identify any unique aspects of the services you provide and/or the individuals and communities you serve. (Max. 350 words)

1. **Please provide a brief summary of the preceptor supervision for student nurses currently available at your organization.** Please be sure to identify any formal and informal agreements with nursing programs, as well as the clinical departments in which preceptor supervision currently takes place. Other details that may be useful to providing a more complete picture of nurse preceptor activities at your organization are welcome, as well. (Max. 500 words)

1. **Please identify the following for FY22[[1]](#footnote-2) for your organization to the best of your ability:**

Number of individual nurses providing preceptor supervision for student nurses:

Total number of nurse preceptor hours completed:

Total number of student nurses for whom preceptor supervision was provided:

Please provide any additional information that may be helpful to understanding/interpreting the numbers above:

1. **Please summarize what you see as the biggest obstacles to implementing and sustaining preceptor supervision for student nurses at your organization** (e.g., salaries, time, geography, work environment, anything else). (Max. 350 words):

1. **Please identify your primary goals for the use of Nurse Preceptor Incentive Grants Program funds at your organization**. Please click all that apply.

[ ]  Recognize, reward, and retain current nurse preceptors

[ ]  Incentivize other nurses currently employed at our organization to take on preceptor responsibilities

[ ]  Help recruit new nurses to our organization

[ ]  Other. Please provide more details:

1. **Please provide a brief narrative explanation for the grant funds requested and any matching funds committed.** Please be sure to identify the clinical departments and/or nursing programs that will benefit from Incentive Pay, as appropriate, if the grant is awarded. (Max. 350 words):

1. **Please briefly describe your plans for sustaining preceptor supervision for nursing students at your organization following the close of the Nurse Preceptor Incentive Grants program.** (Max. 350 words):

1. **Please provide any other information that might be helpful to evaluating your application (optional)** (Max. 350 words):

**The following questions will allow the Agency of Human Services to more quickly complete pre-award activities and process your grant award if you are selected.**

1. **What type of accounting system does your organization use?**

[ ]  Automated

[ ]  Manual

[ ]  Combination

1. **Would this grant award be the first award your organization has received from the State of Vermont?**

[ ]  Yes

[ ]  No

1. **If you have previously received an award from the State of Vermont, did your organization adhere to all terms and conditions of prior grant awards from the State of Vermont?**

[ ]  Yes

[ ]  No

[ ]  Not applicable

1. **Does your organization have adequate and qualified staff to comply with the terms of the agreement?**

[ ]  Yes

[ ]  No

1. **Does your organization have prior experience with similar programs?**

[ ]  Yes

[ ]  No

1. **Does your organization maintain policies which include procedures for assuring compliance with the terms of the award?**

[ ]  Yes

[ ]  No

1. **Does your organization have an accounting system that will allow you to completely and accurately track the receipt and disbursements of funds related to this award?**

[ ]  Yes

[ ]  No

1. **Does your organization have a system in place that will track and account for 100% of each employee’s time?**

[ ]  Yes

[ ]  No

1. **Have there been any significant changes to your organizational structure or service delivery in the last three years?** (e.g., organizational restructuring, new or substantially changed systems, rapid growth, loss of license or accreditation)

[ ]  Yes

[ ]  No

1. **If applicable, please provide any relevant information related to responses to questions 9-17.** (Max. 350 words):

1. You may use the 2022 State Fiscal Year, which operated from July 1, 2021-June 30, 2022, or your organization’s 2022 Fiscal Year. [↑](#footnote-ref-2)