Napa Infant-Parent Mental Health Fellowship Scholarship Application

To apply for Napa Infant-Parent Mental Health Fellowship scholarship from First 5 Yolo, a completed application packet **must be received by First 5 Yolo by November 6, 2018**. Completed packets can be mailed to the First 5 Yolo Office (502 Mace Blvd, Ste 11, Davis, CA 95618) or emailed to lduisenberg@first5yolo.org. If submitting electronically, all required application components must be submitted in a single zip file. Incomplete or late submissions will not be considered.

Required application components:

1) Completed First 5 Yolo application
   a) Applicant Information and Supplemental Questionnaire
   b) Service Hours Acknowledgement and Certification
2) Completed Napa Infant-Parent Mental Health Fellowship application and all required materials. The application can be found at: https://cpe.ucdavis.edu/autism-spectrum-disorder/napa-infant-parent-mental-health-fellowship
   Note: First 5 Yolo will submit the NIPHM application to UC Davis for applicants selected by First 5 Yolo to receive scholarship

APPLICANT INFORMATION

Applicant Name: _____
(first, middle, last)

Mailing Address: _____
(street address)

_____
(city, state, zip)

Home Phone: _____ Work Phone: _____

Cellphone: _____ Email: _____

Educational Data- *enter information for the highest level of education completed*

Name of College or University	City & State	Graduated (MM/YY)	Degree Conferred (e.g., MS, Counseling Psychology)

Professional License Data:

Type of License	Issuing Body	License #	In good standing?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

SUPPLEMENTAL QUESTIONNAIRE

1. Are you currently a certified Medi-Cal Provider? *This is *not required for scholarship eligibility*.
   ☐ Yes ☐ No

2. Briefly describe your current professional work. Include current employer, job functions/title, current work with children 0-5, size and fullness of practice, and work setting.

3. Why are you interested in participating in the Napa Infant-Parent Mental Health Fellowship?

4. After receiving certification through the Napa Infant-Parent Mental Health Fellowship Program, you will be required to provide 140 hours of therapeutic service to children 0-5 identified by Help Me Grow Yolo. These hours must be completed within 12 months of achieving certification. What is your capacity to complete the required hours and proposed plan to integrate these clients into your practice?

5. Please provide any additional information you consider relevant for First 5 Yolo to consider in reviewing your scholarship application.

SERVICE HOURS ACKNOWLEDGMENT AND CERTIFICATION

By signing below I, _____, acknowledge and certify that the following are true:

1. I am aware that I will be required to complete 140 service hours providing therapeutic services to children aged 0-5 and their families who are identified via Help Me Grow Yolo within 12 months of receiving certification in the program. I will sign an Agreement Letter as a condition of scholarships award.
2. I am able to meet all the education, licensing, time, and program hours requirements to receive certification in the Napa Infant-Parent Mental Health Fellowship.
3. I will serve at least one child identified by Help Me Grow Yolo during the course of the Fellowship and this child will be served at no direct cost to the family (e.g., no co-pay or sliding scale fee).
4. I am able to provide therapy to children aged 0-5 in Yolo County
5. I understand that if I am unable to complete the NIPHM Fellowship, I will be required to refund the scholarship amount to First 5 Yolo
6. I understand that I will be required to submit proof of certification at the end of the fellowship by submitting a copy of my Letter of Certification and Conferral Letter
7. I understand that I will collaborate with Help Me Grow Yolo staff to receive referrals and Help Me Grow Yolo will track my service hours
8. I understand that families served in the course of completing my required service hours cannot be directly billed (e.g., copays, sliding scale-fees) for any services rendered (insurance can be billed)

_____ _____

Signature Date

_____

Print Name