



**Wyoming Provider Recruitment Grant  
Program Application**  
Applications Accepted:  
July 31, 2018 – October 1, 2018

**Section I. Applicant Information**

Recruiting Entity Legal Name:

Entity Type: Hospital      Physician      FQHC      RHC      Other

If 'other' please explain:

Business Type Recruiting For: Non-Profit      For-Profit      Other

If 'other' please explain:

Mailing Address:

City:      Zip:

Signature Authority Name/Title:

Phone:      Email:

Grant Contact Name/Title:

Phone:      Email:

**Section II. Vacancy Information**

Provider vacancy type (ie: physician, nurse practitioner, etc.):

Practice arrangement: Employed      Private Practice      Other (specify)

Provider discipline (ie: family practice, pediatrics, neurosurgery, etc.):

Vacancy City:      Vacancy County:

Vacancy Start Date:

### Section III. Funding Requested

The maximum possible award per applicant is \$50,000 and applicants may apply for one or more of the categories and dollar amounts listed below. Please apply only for what your organization requires in order to allow for as many recruiting entities to participate as possible.

Relocation Expenses of up to \$20,000	Amount Requested: \$
Signing Bonus of up to \$30,000	Amount Requested: \$
Malpractice Insurance of up to \$20,000 (up to \$10,000/year for two premium years)	Amount Requested: \$
Recruitment Costs of up to \$10,000	Amount Requested: \$
	Total Funds Requested: \$

### Section IV. Narrative

Please attach a narrative description of the request for an award under the Wyoming Provider Recruitment Grant Program. The narrative should:

A. Describe the circumstances of the vacancy, such as:

- (i) the reason for loss of the current/previous provider or for the creation of a new position;
- (ii) how long the vacancy has existed;
- (iii) previous and/or current recruitment efforts;
- (iv) barriers and challenges encountered in filling the vacancy.

B. Describe your organization's recruitment plan including:

- (i) timeline;
- (ii) advertising;
- (iii) proposed salary and benefits to be offered to the recruited provider;
  - a. include comparable salary and benefits evaluation for the discipline being recruited.

C. Describe why your organization is pursuing a grant under the Wyoming Provider Recruitment Grant Program including:

- (i) recruitment budget including categories and amounts requested in this application;
- (ii) financial need of the organization;
- (iii) impact to the community of continued vacancy.

## Section V. Acknowledgements

A. By signing below, I acknowledge that I have read and understand the Rules and Regulations for the Wyoming Provider Recruitment Grant Program including the restrictions placed on non-compete clauses in Section 6(f). **Initials:**

B. By signing below, I understand that the recruited provider cannot have practiced in the State of Wyoming, including part-time, for a period of twenty-four (24) months prior to the recruitment offer. Completion of residency at the University of Wyoming Family Medicine Residency Program and practice as part of active duty military service are the only exceptions. **Initials:**

C. By signing below, I understand that if selected for an award under the Wyoming Provider Recruitment Grant Program, payment will be made on a reimbursement basis only after the recruited provider relocates to the approved community and begins full-time practice. In the event the provider does not relocate and begin practice, or does not meet the eligibility requirements set forth in the Program Rules and Regulations or the award contract, I acknowledge that no funds will be received under the award except as indicated under Section 9(b) of the Program Rules and Regulations. **Initials:**

D. By signing below, I understand that if selected for an award under the Wyoming Provider Recruitment Grant Program, the award contract will be between the Wyoming Department of Health, Public Health Division, Office of Rural Health and my organization as the recruiting entity. The recruited provider will not be a party to the award contract and as a result, I, or the organization I represent, will be responsible for any and all repayments, including penalties, if the recruited provider fails to meet the requirements as set forth in W.S. 35-1-1101, the Rules and Regulations, or the award contract. I acknowledge that the Wyoming Department of Health, Public Health Division, Office of Rural Health strongly recommends language in the recruitment offer and/or employment agreement allowing the recruiting entity to recover all payments made, including penalties, from the recruited provider should the recruited provider fail to meet the requirements of the Wyoming Provider Recruitment Grant Program at any time during the term of the award contract. **Initials:**

**Authorized Signature:**

**Name and Title of Authorized Individual:**

**Date:**

**Please submit this completed and signed application document and attached narrative to:**

Keri Wagner  
Healthcare Workforce and Primary Care Office Manager  
Office of Rural Health  
6101 Yellowstone Rd. Ste. 420  
Cheyenne, WY 82002 (regular mail) or 82009 (FedEx, UPS)  
PH: (307) 777-6512  
[keri.wagner@wyo.gov](mailto:keri.wagner@wyo.gov)

**Applications are due by  
October 1, 2018!**