**Nurse Support Program II FY 2027 Competitive Institutional Grants Cover Sheet**

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| **Lead Applicant Institution/Organization:** | | |
| **Project Title:** | | |
| **Partnership Members:** | | |
| **Project Duration:** | | |
| **Funding Requested:** | **Value of Match (Funds, In-Kind, Etc.):** | |
| **Type of Grant:** ☐Planning ☐Implementation ☐Continuation ☐Resource Grant (*if applicable*, check below)  ☐P.D. Resource Grant ☐S.S. Resource Grant | | |
| **Type of Competitive Grant Initiative (CHOOSE ONLY ONE):**  ☐1. Initiative to Increase Nursing Pre-Licensure Enrollments and Graduates  ☐2. Initiative to Advance the Education of Students and RNs to BSN, MSN, and Doctoral Level  ☐3. Initiative to Increase the Number of Doctoral-Prepared Nursing Faculty  ☐4. Initiative to Build Collaborations between Education and Practice  ☐5. Initiative to Increase Capacity Statewide  ☐6. Initiative to Increase Cohen Scholars as Future Faculty and Clinical Educators  ☐7. Initiative to Increase education that advances practice in community health settings/ advances population health | | |
| **Projected Outcomes:** (Identify below the number of additional outcomes expected from funding) | | |
| **Final Outcomes** | | **Projected Increase (# of Additional)**  **Describe Degrees/Results** |
| Nursing Pre-Licensure Graduates | |  |
| Nursing Higher Degrees Completed (describe) | |  |
| Nursing Faculty at Doctoral Level | |  |
| Collaborative, Statewide or Community/ Population Health Results (specify) | |  |

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| Project Director’s Name:  Title:  Mailing Address:  Phone: E-Mail Address:  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Grants Office Contact Name:  Title:  Phone: E-Mail Address:  Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Finance Office Contact Name:  Title:  Phone: E-Mail Address:    Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Authorized Institutional Representative’s Name:  Title (President, Vice President, or Dean/Director of Nursing) :  I certify that the statements herein are true, complete, and accurate to the best of my knowledge. I further certify that if grant funds are awarded, this institution accepts the obligation to comply with terms and conditions set by the Health Services Cost Review Commission and the Maryland Higher Education Commission.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Authorized Institutional Representative’s Signature Date |