



**Office of
Mental Health**

Community Mental Health Loan Repayment Program: Mental Health Clinicians

CMHLRP 2026 MH Clinicians RFP

Application Form

Application Deadline: March 20, 2026
Email Applications to: OMH.CMHLRP@omh.ny.gov

General Instructions

- The applicant agency, applying **on behalf** of an eligible professional working at the agency's eligible program(s), must evaluate whether they and/or the professional meet the criteria, and complete the application as instructed.
- Please complete all fields to the best of your ability so we can review your application in a timely manner.
- All attestations must be **signed by a representative of the applicant agency other than the listed professional**, unless otherwise noted, for the application to be considered completed.
- Applications are reviewed on a first-come, first-served basis with a **deadline of 3/20/26**.
- The applicant agency must maintain contemporaneous records for all claims related information and any other data or documents used to demonstrate that a participating professional was eligible to receive such award, including but not limited to the CMHLRP Agency Loan Repayment and Service Commitment Agreement. All records, data and other information must be made available to OMH for review upon request.
- For any application resulting in an award, the applicant agency must enter into a CMHLRP Agency Loan Repayment and Service Commitment Agreement with each participating professional outlining the professional's eligibility requirements, including but not limited to the full 3-year service commitment, the CMHLRP award start and end dates, the agency's payment terms for distributing CMHLRP funds to the professional(s), and a legally binding recoupment mechanism. The CMHLRP Agency Loan Repayment and Service Commitment Agreement is **not** due at time of application; it must be completed upon execution of the contract with OMH.
- During the second and third year of the award/service commitment, the applicant agency will complete and submit attestations confirming the participating professional's continued eligibility as requested by OMH. Payments for Year 2 & 3 are dependent on completion of the attestations and will not be sent until completed and returned.

Any questions regarding the application and all completed applications should be emailed to OMH.CMHLRP@omh.ny.gov.

Application Sections

- **Section A** – Applicant Information
 - Applicant Agency Information
 - Nominated Professional's Information
- **Section B** – Agency Verification of Employment
 - Work at Eligible Program(s)
 - Clinical Capacity Schedule
- **Section C** – Agency Verification of Professional's Qualifying Loan
- **Section D** – Agency Verification of Professional's Eligibility
- **Attachment A** – Sexual Harassment Prevention Certification Form
- **Attachment B** – Gender-Based Violence and the Workplace Certification Form
- **Attachment C** – (Optional) Professional Verification of Diversity, Equity and Inclusion Set Aside Eligibility

Please refer to the [Program Overview](#), [Definitions & Background](#), and [FAQ](#) documents on the [OMH RFP Page](#). All applications must be submitted by email to OMH.CMHLRP@omh.ny.gov.

Section A - Applicant Information

Applicant Agency Information

1. Agency Name:

2. Agency Type:

All eligible applicants must be registered in Grants Management in the State Financial System (SFS). **Not-for-profit agencies must be Prequalified.** Please see the Prequalification Requirement section of the [Program Overview](#) for more. Information on becoming registered and prequalified can be found on the [NYS Grants Management site](#).

☐ Not-for-profit agency with 501(c)(3) incorporation ☐ For-profit agency ☐ Government entity

3. Main Program Name:

Please choose the program name that starts with your agency's five-digit OMH Agency Code as listed in the Agency Name field. If you cannot find your Program Name, please provide additional information in the "Additional Information" field and the OMH Operating Certificate.

4. Program Address:

5. For CCBHC, please provide the name of the associated MHOTRS site:

6. Additional Programs (if applicable):

If the professional works at more than one eligible program, you may apply for the total hours they work at eligible program(s). Please provide the name(s) of any additional programs below, **as listed in the above Program Name dropdown menu**.

Section A - Applicant Information *(continued)*

The **agency contact(s)** are responsible for coordinating and communicating within your **agency** to determine and monitor the professional's eligibility, to **convey information to OMH** necessary for contracts and payments, and for **communicating with the professional** regarding this application and your Agency's Loan Repayment and Service Commitment Agreement should this application result in an award.

Agency Contact(s) for CMHLRP

7. Primary Agency Contact Name:

8. Primary Agency Contact Phone #:

9. Primary Agency Contact Email:

10. (Optional) Additional Contact Name(s):

11. (Optional) Additional Contact Phone #(s):

12. (Optional) Additional Contact Email(s):

13. Additional Information (if applicable):

Section A - Applicant Information *(continued)*

If you are submitting multiple applications **at the same time**, please provide a priority order for this professional's individual application. If you are submitting multiple applications at the same time, they will **not** be processed until a priority order is provided.

Nominated Professional's Information

14. Priority Order #:

_____ of _____ (total number of applications being submitted at the same time)

15. Professional's Name:

16. Professional License Title:

17. 6-digit New York State License #:

18. Professional's Total Student Loan Debt:

19. CMHLRP Eligibility Start Date:

The CMHLRP Eligibility Start Date should reflect the earliest date the professional will be **fully eligible** for CMHLRP. This date should be **no earlier than 3/21/26 and no later than 5/21/26** for the CMHLRP 2026 MH Clinicians RFP.

20. How long has the professional worked at this agency?

___ Less than 1 year

___ 1-to-5 years

___ Greater than 5 years

Please refer to the [Program Overview](#), [Definitions & Background](#), and [FAQ](#) documents on the [OMH RFP Page](#). All applications must be submitted by email to OMH.CMHLRP@omh.ny.gov.

Section B - Agency Verification of Employment

1. Is the professional listed above currently working at the eligible program(s) listed above?

___ Yes ___ No

If not and this is for a **recruitment**, please provide the **anticipated employment start date** below:

If this professional is an **academically affiliated contractor**, you **must provide additional information** regarding the arrangement for review (see [Definitions & Background](#) for more regarding academically affiliated contractors):

-
2. Will the professional listed above provide a clinical capacity schedule (see [Definitions & Background](#)) at the eligible program(s) listed above for the duration of the 3-year service commitment?

___ Yes ___ No

3. Please provide the hours that the professional will be working at the eligible program(s) listed above:

Total Hours per Week: _____

Clinical Hours per Week: _____

If the professional works at multiple locations, indicate how many of their hours are spent at each program in the space below:

Agency Verification of Employment Attestation

As a representative of the applicant agency, I declare, affirm, and certify that I, the undersigned, attest that the professional listed above will work at the eligible program(s) listed in this application for the award service period and that they will be working the clinical capacity schedule indicated above. I understand that failure to maintain this eligibility for the full 3-year service commitment will result in the full CMHLRP award amount being revoked.

Name and Title: _____

Signature: _____

Date of Signature: _____

Section C - Agency Verification of Professional's Qualifying Loan

Please refer to the [Program Overview](#), [Definitions & Background](#), and [FAQ](#) documents on the [OMH RFP Page](#). All applications must be submitted by email to OMH.CMHLRP@omh.ny.gov.

1. Does the professional listed above have qualifying student loans, defined as: "the principal, interest, and related expenses of outstanding government (federal, state, or local) and commercial (private) student loans for undergraduate or graduate education obtained by the professional for school tuition, other reasonable educational expenses, and reasonable living expenses"?

___ Yes ___ No

2. Is this professional in student loan forbearance or deferment (temporary periods during which a student loan borrower is not required to make payments which are approved by the student loan lender and/or servicer. This repayment status is typically indicated on student loan statements and does not impact eligibility. See Qualified Student Loan Debt in the [Program Overview](#) for more)?

___ Yes ___ No

3. Is this professional tracking payments for Public Service Loan Forgiveness (PSLF)?

___ Yes ___ No

4. If yes, how many payments does the professional have before forgiveness (120 minus [payments tracked toward PSLF to date](#))?

Please Note: You, the applicant agency, will be required to keep a copy of the professional's loan documentation used to verify the qualifying loan amount and PSLF participation if applicable. Eligible professionals tracking payments toward Public Service Loan Forgiveness (PSLF) must have at least 40 payments remaining before forgiveness as of 5/21/26. The professional will be responsible for providing this documentation to the agency. OMH may from time-to-time request such documentation to confirm and verify qualifying loan information. You the applicant agency will be required to furnish such documentation to OMH upon request.

Agency Verification of Professional's Qualifying Loan Attestation

As a representative of the applicant agency, I declare, affirm, and certify that I, the undersigned, have reviewed the qualifying loan documentation provided by the professional listed above and attest that to the best of my knowledge the above is true and correct. I understand that failure to maintain this eligibility for the full 3-year service commitment will result in the full CMHLRP award amount being revoked.

Name and Title: _____

Signature: _____

Date of Signature: _____

Section D - Agency Verification of Professional's Eligibility

1. Agencies are required to review the following professional eligibility criteria and indicate verification by *initialing or checking* each item to confirm that the professional listed above meets the corresponding requirement. This must be completed by an authorized representative for the agency and cannot be completed by the professional.

- ☐ Is a U.S. citizen or permanent resident alien holding an I-155 or I-551 card (green card)
- ☐ Is licensed to practice in New York State as an LMSW, LCSW, LMHC, LMFT, LCAT, OTR/L or OT/L, psychoanalyst, or psychologist
- ☐ Is in good standing with: NYS Department of Education
- ☐ Has qualified student loan debt that can be repaid
- ☐ Is not in breach of a health professional service obligation to federal, state, or local government, does not have any judgment liens arising from federal or state debt, and is not delinquent in child support payments
- ☐ Is not fulfilling a service commitment for any other loan repayment program where the commitment period of that repayment program would overlap or coincide with the CMHLRP service commitment period and if participating in PSLF has more than 40 payments before forgiveness from 5/21/26 (please also see Section C above)
- ☐ Is not the recipient of a current or past CMHLRP award, unless such award was withdrawn and any CMHLRP funding received has been repaid in full before time of application to this CMHLRP RFP
- ☐ Works a clinical capacity schedule providing direct care mental health services, assessment, and treatment, within the professional's licensed scope of practice at the applicant agency's eligible program(s)

2. Does the professional listed above meet all the eligibility requirements as outlined above?

☐ Yes ☐ No

Agency Verification of Professional's Eligibility

As a representative of the applicant agency, I declare, affirm, and certify that I, the undersigned, have reviewed the eligibility requirements of this award as well as the professional's eligibility and attest that to the best of my knowledge the above is true and correct. I understand that failure to maintain this eligibility for the full 3-year service commitment will result in the full CMHLRP award amount being revoked.

Name and Title: _____

Signature: _____

Date of Signature: _____

Attachment A – Sexual Harassment Prevention Certificate

For Attachment A, please complete the Sexual Harassment Prevention Certification form completely and submit with the application.

1. For the Solicitation # and/or OMH descriptive name of solicitation, please put: **“CMHLRP 2026 MH Clinicians RFP.”**
2. For “Offerer” please list your **Agency Name**.
3. The form should be signed by the contact at your agency who can attest to the agency’s written policy and training addressing sexual harassment prevention in the workplace. We cannot speak to the specific contact at your agency, but we recommend reaching out first to your Human Resources (HR) department if you are unsure. The only stated restriction is that the professional your agency is applying on behalf of should **not** be completing and signing this form.

NOTE: State Finance Law Section 139_I requires applicants on state procurements to certify that they have a written policy addressing sexual harassment prevention in the workplace and provide annual sexual harassment training (that meets the Department of Labor’s model policy and training standards) to all its employees. Applications that do not contain the certification may not be considered for award; provided however, that if the applicant cannot make the certification, the applicant may provide a statement with their bid detailing the reasons why the certification cannot be made. A template certification document is being provided as part of this RFP. Applicants must complete and return the certification with their application or provide a statement detailing why the certification cannot be made.



Sexual Harassment Prevention Certification

Solicitation # and/or OMH descriptive name of solicitation:

State Finance Law §139-l requires bidders on state procurements to certify that they have a written policy addressing sexual harassment prevention in the workplace and provide annual sexual harassment training (that meets the Department of Labor's model policy and training standards) to all its employees.

By submission of this bid, each bidder and each person signing on behalf of any bidder certifies, and in the case of a joint bid each party thereto certifies its own organization, under penalty of perjury, that the bidder has and has implemented a written policy addressing sexual harassment prevention in the workplace and provides annual sexual harassment prevention training to all of its employees. Such policy shall, at a minimum, meet the requirements of section two hundred one-g of the labor law.

I hereby affirm that _____ (**offerer's name**) has implemented a written policy addressing sexual harassment prevention in the workplace and provides annual sexual harassment prevention training to all of its employees. Such policy, at a minimum, meets the requirements of section two hundred one-g of the labor law. Unless I provide notice otherwise, my execution of this affirmation shall be an ongoing representation that I have complied with, and continue to be in compliance with State Finance Law §139-l.

I understand and agree that: 1) OMH shall have the right to terminate the contract, purchase order or purchase authorization resulting from this solicitation in the event that this affirmation is found to be intentionally false or intentionally incomplete; and 2) upon such finding, OMH may exercise its termination right by providing written notification.

Date:

Signature of Authorized Representative:

Printed Name and Title:

Name of Offerer:

Offerer's Address:

Attachment B - Gender-Based Violence and the Workplace Certification

For Attachment B, please complete the Gender-Based Violence and the Workplace Certification form completely and submit with the application.

1. Organization refers to your **Agency Name**.
2. The form **must** be signed by an authorized executive or legal representative at your agency.

NOTE: State Finance Law §139-m requires all vendors bidding on state contracts to implement and attest to a Gender-Based Violence and the Workplace policy. Applicants on state procurements must certify that they have a written policy addressing gender-based violence and the workplace that meets the minimum requirements of State Finance Law §139-m. Applications that do not contain the Gender-Based Violence and the Workplace Certification may not be considered for award; provided however, that if the applicant cannot make the certification, the applicant may provide a statement with their bid detailing the reasons why the certification cannot be made. A template certification document is being provided as part of this RFP. Applicants must complete and return the certification with their application or provide a statement detailing why the certification cannot be made.



Gender-Based Violence and the Workplace Certification

New York State Finance Law §139-M requires bidders on competitive state procurements to certify that they have a written policy addressing gender-based violence and the workplace and that such policy meets the following minimum requirements:

- **Share Information:** Employers must provide information regarding gender-based violence where employees can see and access it, including displaying the NYS Domestic and Sexual Violence Hotline information and a gender-based violence and the workplace poster.
- **Refer Employee-Survivors to Services:** The policy must require that the employer refer employees who disclose current or past victim status to the NYS Domestic and Sexual Violence Hotline and/or a local service provider. For bidders outside of New York State, referrals should be made to a local provider or statewide hotline. While referrals are required to be provided by the employer, it is not required for the employee to access services.
- **Prohibit Retaliation:** The policy must clearly state that discrimination or retaliation against employees who identify as victims or survivors of gender-based violence is prohibited.
- **Comply with Laws:** Ensure your policy follows State law. For employers based in New York State, this means that the policy must follow the SAFE Leave Act, New York State Human Rights Law, and any other relevant laws and regulations.
- **Offer Implementation Support:** OPDV is able to assist employers in developing and implementing this policy. Employers must provide information to supervisors and human resources, where available, about this technical assistance from OPDV. OPDV can be contacted at workplace@opdv.ny.gov

By submission of this certification, each person signing on behalf of any organization certifies, and in the case of a joint submission each party thereto certifies its own organization, under penalty of perjury, that they have and have implemented a written policy addressing gender-based violence and the workplace. Organization's signature below certifies its compliance with State Finance Law §139-M.

Organization: _____

Signature of Authorized Representative: _____

Printed Name and Title: _____

Date: _____

This form must be signed by an authorized executive or legal representative.

If the organization cannot make the above certification, they must provide a statement with their bid detailing the reasons therefor:

Attachment C – (Optional) Professional Verification Diversity, Equity and Inclusion Set Aside Eligibility

Eligible agencies may apply for award funding set aside for eligible professionals who provide cultural competency for populations underserved in mental health as a member of a group traditionally underrepresented in the mental health field.

This form is not required for applicants who are not applying for this set aside funding.

Applications for the DEI Set Aside must include this form, which must be completed by the nominated professional.

I, the nominated professional, meet the eligibility requirement for the Diversity, Equity, and Inclusion set aside as a member of the following under-represented group(s) – *please check all that apply*:

- ☐ African American
- ☐ Alaska Native
- ☐ Black
- ☐ American Indian
- ☐ Asian
- ☐ Hispanic
- ☐ Individual with a Disability
- ☐ Latine / Latinx
- ☐ LGBTQ+
- ☐ Middle Eastern
- ☐ Native Hawaiian
- ☐ North African
- ☐ Pacific Islander

Professional's Attestation of Set Aside Eligibility

I, the nominated professional, declare, affirm, and certify that I, the undersigned, have reviewed the eligibility requirements of this award as well as my eligibility and attest that to the best of my knowledge the above is true and correct.

Name and Title: _____

Signature: _____

Date of Signature: _____