

## STONY BROOK UNIVERSITY ADDICTION PROFESSIONALS SCHOLARSHIP PROGRAM APPLICATION

**Applicant Information:**

Full Name*			
	First Name*	Middle Name/Initial	Last Name*
Residential Address*			
	Street Address*		Apt/Suite #
	City*	State*	Zip Code*
Mailing Address (if different than residential address)			
	Street Address		Apt/Suite #
	City	State	Zip Code
Phone Numbers* (000) 000-0000			
	Mobile* (primary)	Home	Business
Personal Email Address*			
Business Email Address			
Emergency Contact Information* (Name, Relation, Phone Number)			

*\* required fields*

**APPLICANT TYPE** (Please check only one of the following categories either 1 or 2):

**1. I am an employee of one of the following Program types:**

- ☐ Office of Addiction Services and Supports (OASAS) certified/authorized program
- ☐ Office of Mental Health (OMH) or Department of Health (DOH) certified
- ☐ Integrated Outpatient Services (IOS-SUD) Program
- ☐ Department of Health (DOH) Drug user Health/Harm Reduction Program
- ☐ Non-certified setting which involves either: 1) the legal provision of addiction services or 2) the opportunity to establish proficiency in one or more of the professional competencies associated with a credential administered by OASAS (that provides addiction care prevention, treatment, recovery or harm reduction services in another setting).
- ☐ I am not currently working in one of the above settings.

**2. Please select your highest level of education.**

- ☐ Doctoral degree
- ☐ Master's degree
- ☐ Bachelor's degree
- ☐ Associate degree
- ☐ High school diploma/high school equivalency diploma
- ☐ None of the above

**3. Has any disciplinary action ever been taken against you as the holder of any license or certification issued by New York State or any other State or Federal agency?**

- ☐ Yes
- ☐ No

If you answered "yes", please explain below.

**4. Are you listed on the Staff Exclusion List\* as an individual who is legally prohibited from providing care and services to a vulnerable person? \*defined in Article 11 of the New York State Social Services Law**

- ☐ Yes
- ☐ No

If you answered "yes", please explain below.

**5. I am an individual/student who is interested in working in one of the OASAS/OMH/DOH settings reflected below (please check all that apply):**

- ☐ Interested in the Office of Addiction Services and Supports (OASAS)
- ☐ Interested in the Office of Mental Health (OMH)
- ☐ Interested in the Department of Health (DOH)

**PROGRAM TYPE (Choose One):**

- ☐ Credentialed Alcoholism and Substance Abuse Counselor (CASAC) 350-hour
- ☐ CASAC 100-hour (for individuals with a qualifying master's degree or higher clinical degree)

Have you taken the CASAC program at another Education and Training Provider (ETP) prior to applying to Stony Brook University?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

If you answered “yes” to the previous question, please provide the following: 1) the name of the ETP; 2) a brief description of the course and content that you successfully completed including the sections, modules, and hours completed; and 3) the sectional certificate that you received from the ETP from which you are transferring.

Did you receive a scholarship from OASAS to attend the CASAC program from the ETP from which you are transferring?

\_\_\_\_\_ Yes  
\_\_\_\_\_ No

If you answered “yes” to the previous question, please list the name of the scholarship and the year that you received it.

Name of OASAS scholarship: \_\_\_\_\_

Year scholarship was received: \_\_\_\_\_

**REQUIRED SCHOLARSHIP APPLICATION DOCUMENTS** (Please visit our [webpage](#) for more specific details and application requirements):

1. Copy of High School Diploma, High School Equivalency diploma, and College Transcripts or College degree.
2. If not currently employed in the Addictions field, a brief statement (500 words or fewer) about why you are applying for a scholarship opportunity for your selected program type, which should include, at a minimum: any previous volunteer experience or work experience along the addictions continuum of care; your interest in working in the OASAS Provider System; and the qualities you possess that you believe would make you an effective CASAC is required.

3. Employment Verification Form (only required for applicants who selected one of the employment options in Priority 1)
4. Three (3) Reference Forms/Letters of Recommendation clearly indicating the signatory's credentials/title/qualifications to write on the applicant's behalf (Employment Verification Form may be submitted in lieu of one (1) Reference Form/Letter of Recommendation and is REQUIRED for any applicants who are working in an OASAS/OMH/DOH certified setting and/or within a setting along the addictions continuum of care at the time of application)

One (1) professional or academic reference and two (2) personal references (for individuals not currently employed in the addictions field and are unable to obtain three (3) professional references). A professional reference or academic reference may include a professor, a supervisor, a teacher, or a HSE instructor. Personal references are people who you know from settings outside of work, including community organizations and social groups. They may include: mentors; people you know from networking or professional membership groups; leaders of social groups and community organizations; coaches or instructors from extracurricular activities; faith leaders; and someone who has worked with you on a project or assignment.

Please note that personal references do not include family members, your spouse or personal friends. Your personal references should be able to speak objectively about your character and/or about your job-related skills.

5. Review summary from OASAS (for individuals who received a transcript review from OASAS to obtain transfer credits).
6. Sectional Certificate (for individuals who took classes at a previous ETP and want to receive transfer credits).

\_\_\_\_\_ Please initial this section **ONLY** if you agree to having your name and program selection shared with the NYS Office of Addiction Services and Supports (OASAS) for inclusion in their data collection regarding the scholarship program. This is completely voluntary and will NOT, in any way, affect your potential eligibility for a scholarship opportunity. Information will only be shared if you are selected to receive, and agree to accept, an OASAS-funded scholarship award.

**Please specify your preference for class and start date on the line below.**

CLASS	ESTIMATED START DATE	ESTIMATED END DATE
Cohort 3 (85 Hr. )	May, 2026	August, 2026
Cohort 8 (350 Hr.)	May, 2026	August, 2027

My 1<sup>st</sup> preference is: \_\_\_\_\_ .

**Note:** If you are accepted into and withdraw from the scholarship program, you may not receive another scholarship from OASAS in the future.

**Statement of Accuracy/Affirmation**

I affirm that all the information I have provided in this application is my work and that it is accurate to the best of my knowledge and belief.

I affirm that I am not currently receiving another scholarship from the New York State Office of Addiction Services and Supports.

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Applicant's Name [Printed]

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Applicant's Signature

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Date (MM/DD/YYYY)

Admission into your preferred class may or may not be accommodated pending availability of seats for each class. This does not guarantee your admission into our program.