



2017 Rhode Island Health Professional Loan Repayment Program Application

Applicant Name _____

Date _____

DOCUMENT CHECKLIST FOR HEALTH PROFESSIONALS

This checklist has been provided to facilitate the application process. In order to be considered, applications must contain the information noted on the list below.

APPLICATIONS MISSING ANY INFORMATION OR NOT SUBMITTED BY THE DEADLINE WILL NOT BE REVIEWED.

Please check off each applicable item. Your completed "Document Checklist" should be submitted with your application. Documents should be submitted in the order that they appear on the checklist.

SECTION 1. Health Professional Information Forms

- Health Professional Information Form completed and signed by the applicant (health professional)
 - Copy of the health professional's current resume or curriculum vitae
 - Copy of the health professional's current Rhode Island professional license
 - Proof of US citizenship for the health professional (provide a copy of passport or birth certificate)
- Essay

SECTION 2. Financial Forms

- Permission to Verify Loan Balances Form completed and signed by the applicant
- Health Professional's Qualifying Loan Statement(s) and Pay Stub Form
 - Credit Authorization Form
 - W-9 Form (Verification of Taxation Reporting Information) <http://www.irs.gov/pub/irs-pdf/fw9.pdf>

SECTION 3. Employer Forms

- Employer Information Form completed and signed by appropriate employer representative
 - Copy of non-profit or not-for-profit documentation for the healthcare employer organization or practice site (not required for applicants working in a Federally Qualified Health Center)
 - A copy of sliding fee scale and policy of practice site. Sliding fee scale should reflect current federal poverty guidelines.
- Statement of Need
- Payor Mix Information Form completed and signed by authorized representative

Keep a copy of the entire application for your records.

Mail to: Dr. Margaret Gradie
 Department of Health – Office of Primary Care & Rural Health
 3 Capitol Hill, Room 304
 Providence, RI 02908

Pursuant to Rhode Island General Law § 42-46-5 you are hereby notified that your application before the Rhode Island Health Professional Loan Repayment Program Board will be discussed during closed session; however, you may require your application be discussed during open session.

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SECTION 1. Health Professional Information Form

PERSONAL INFORMATION

First name Last name MI

Home address Date of Birth

City State Zip code Country

Home phone Work phone

Email

Residence prior to health professional education

City State Zip code Country

Gender M F Other Decline to answer

Are you Hispanic/Latino? Yes No Decline to answer

What race(s) do you most identify with? Check all that apply:

Asian White Black Native Hawaiian/Other Pacific Islander
 American Indian/Alaskan Native Other Decline to answer

Languages: In addition to English, indicate language(s), you speak with sufficient fluency to provide adequate healthcare:

- I am applying as a Full Time service provider working **40 hours** (with no more than 8 hours per week of teaching or practice-related administrative activities) per week at a HPSA site for a **2 year** service commitment.
- I am applying as a Half Time service provider working **20-39 hours** (with no more than 4 hours per week of teaching or practice-related administrative activities) per week at a HPSA site for a **4 year** service commitment.

PROFESSIONAL INFORMATION

Are you enrolled in any of the following military services?

- Army Reserve Navy Reserve Army National Guard Marine Corps Reserve
 Air Force Reserve Air National Guard Coast Guard Reserve Other:

Profession (check all that apply): Applicants must have completed a course of study required to practice independently without supervision. Note: Physicians who have not completed residency programs are not eligible for funding under the HPLRP.

- CNM Certified Midwife
 DD Dentist (D.D.S. or D.M.D.)
 DH Dental Hygienist
 DO Doctor of Osteopathic Medicine
 HSP Psychologist (Ph.D. or Ed.D.)
 LICSW Licensed Clinical Social Worker (master's / doctoral degree in social work)
 MD Doctor of Allopathic Medicine
 MFT Marriage & Family Therapist (master's / doctoral degree with a major study in marriage & family therapy)
 MHC Mental Health Counselor (master's / doctoral degree with a major study in counseling)
 PA Physician Assistant
 APRN Advanced Practice Registered Nurse/Certified Nurse Practitioner
 RN Registered Nurse
 PharmD Pharmacist

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PROFESSIONAL INFORMATION (continued)

Specialty: (e.g. Family Medicine)

Current License #

License Expiration Date

Board certified? Yes No

Other professional certification(s)

Practice site name

Practice site address

City

State

Zip code

Please indicate the number of hours you are scheduled to work per week

hrs/wk

If you work in more than one site, identify second site

Percent of time spent providing care at second site

How long have you been employed by this practice?

Less than 1 year 1.0 - 1.5 years 1.6 - 2.5 years 2.6 - 3.5 years 3.6 years or more

Have you previously received award(s) from the RI HPLRP?

Yes No If Yes, date of previous award _____

Do you have a current commitment to any of the following student loan repayment programs:

Yes No

Please indicate whether you have a current commitment to any of the following study loan repayment programs and, if so, the **number of months remaining** in the time commitment. (Please add other commitments on a separate page and include it with the application.)

National Health Service Corps	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:
RIFEL Nursing Rewards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:
Nurse Educator Rewards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:
Primary Care Loan Repayment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:
Loan Repayment for Dental Professionals	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Months:

School attended for health professional training

School City/State

Year of graduation

Name of residency training program

Residency City/State

Date of completion

Undergraduate college or university

Year of graduation

How did you hear about the program?

Rhode Island Department of Health / Primary Care Office website
 College / University Career Services Residency Employer
 RI Student Loan Authority (RISLA) Presentation at college / university Colleague
 Internet search Other

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SECTION 1. Essay

CHOOSE ONE OF THE TWO ESSAYS

CLEARLY INDICATE WHICH ESSAY QUESTION YOU ARE ANSWERING. Essay should be 400-500 typed words. Please complete essay in the space below, or on a separate sheet of paper and attach to the application package. Please make sure to write the question you intend to answer at the top of the document. Include in the header your name, the name of the practice site, and the date of your application.

1. Describe your education, practice, and other relevant experiences which you believe qualify you to work in an underserved community or with underserved populations. Please give concrete examples of what has prepared you to work with the population served by your current site.
2. Describe your patient population including health disparities experienced by that population. Describe how you as a healthcare provider have been addressing or will address these disparities and / or improve the health outcomes of the patient population (e.g. through community outreach / education, support groups, research).

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PROVIDE AFFIRMATION OF THE ELIGIBILITY CRITERIA BY INITIALING THE FOLLOWING ITEMS:

STATEMENT

**AFFIRMATION
(INITIALS)**

I, the applicant, am a United States citizen or a naturalized citizen.

I have no outstanding contractual obligation for health professional service to the federal government, or to a state or other entity, that will not be completely satisfied before the RI HPLRP contract has been signed. I am aware that certain bonus clauses in employment contracts may impose a service obligation.

I understand that I am eligible to participate in the RI HPLRP if I am in the Reserve component of the US Armed Forces or National Guard. If I participate in military training and/or service, in combination with other absences from the service site that exceed 35 work days per service year, the RI HPLRP service obligation will be extended to compensate for the break in "full-time" service.

I acknowledge that a qualifying educational loan is any outstanding Government (Federal, State, or local) and commercial (i.e., private) student loan for undergraduate or graduate education obtained by me for school tuition, other reasonable educational expenses, and reasonable living expenses. The educational loans were obtained prior to the date of submission of the application to the loan repayment program. I understand that Parent Plus Loans, Personal Lines of Credit, Loans Subject to Cancellation, Residency Loans, Credit Card debts & promissory notes are NOT qualifying loans.

I agree to provide primary care services to any individual seeking care and will not discriminate on the basis of the patient's ability to pay for care or on the basis that payment for care will be made pursuant to Medicaid, the Rite Care Health Insurance Program, Medicare, and/or through the sliding fee scale.

I agree to provide permission to my employer to release information regarding my work hours, vacation time and related information to the RI HPLRP.

I do not have a judgment lien against my property for a debt to the United States.

I do not have a significant history of failing to comply with, or inability to comply with, service or payment obligations (e.g. Health Education Assistance Loans, Nursing Student Loans, Federal Income Tax Liabilities, Federal Housing Authority loans).

I have a valid contract for a two-year full-time or a four-year part-time commitment to provide services at a site that has been approved for funding.

I will have a current and non-restricted license to practice in the state of Rhode Island, appropriate for the health profession discipline by the start of the contract.

DECLARATION: THIS DECLARATION FORM MUST BE SIGNED BY THE HEALTH PROFESSIONAL APPLICANT

All of the information on this application is truthful and accurate. I understand that knowingly submitting false information will void this application and may be considered a breach of my Rhode Island Health Professional Loan Repayment Program (RI HPLRP) for Health Professionals contract.

I agree to sign a contract with the Rhode Island Department of Health / Office of Primary Care and Rural Health to provide two years of full-time service or equivalent in four years of part-time service at an eligible employer healthcare organization according to the specifications in the RI HPLRP program description. By signing this application, I agree to all of the conditions stipulated in the RI HPLRP program description.

SIGNATURE OF HEALTH PROFESSIONAL APPLICANT

Signature

Date

Print Name and Title

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SECTION 2. FINANCIAL FORMS: Permission To Verify Loan Balances

INSTITUTION/LENDER INFORMATION

To Whom It May Concern:

In order that I may participate in the Rhode Island Health Professional Loan Repayment Program, I hereby authorize:

Name of Institution/Lender

Institution/Lender Address

City State Zip code Country

Institution/Lender Telephone Number

Institution/Lender Federal ID#

to release to the Rhode Island Higher Education Assistance Authority (RIHEAA), any information about loans requested by RIHEAA. This information is for the use of RIHEAA in verifying student loans.

A copy of this authorization may be deemed to be an original.

Thank you for your assistance in this matter. Your prompt reply and cooperation will help to expedite my loan repayment.

APPLICANT'S INFORMATION

Applicant's Name

Applicant's Address

City State ZIP code Country

Telephone

E-mail

Account Number

Social Security Number

Applicant's Signature

Date

Correspondence Address:

Rhode Island Higher Education Assistance Authority
560 Jefferson Blvd
Warwick, RI 02886
PHONE (401) 736-1100
FAX (401) 732-3541
TDD 277-6195

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Health Professional's Qualifying Loan Statement(s) and Pay Stub Form

STUDENT LOAN INFORMATION

Please attach a copy of your student loan statement(s) and a copy of a pay stub. The loan statement(s) and pay stub should be from the month prior to, or month of, this application. On the loan statement(s), please HIGHLIGHT each outstanding loan. Below please list each student loan dollar amount. Amount awarded by the RI HPLRP will not exceed total loan amount.

Student loan carrier

Account Number Loan amount \$

Total loan amount \$

What is your current total annual salary? \$

What is the amount you are requesting from the RI HPLRP? \$

***Include a copy of a pay stub from your practice site from the month prior to, or month of, this application.**

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RHODE ISLAND HIGHER EDUCATION ASSISTANCE AUTHORITY

CREDIT REPORT AUTHORIZATION AND PRIVACY DISCLOSURE FORM

I hereby authorize and instruct Rhode Island Higher Education Assistance Authority to obtain and review my credit report. My credit report will be obtained from Experian reporting agency chosen by RIHEAA. I understand and agree that RIHEAA intends to use the credit report for the purpose of identifying any state, federal or private loans that I have outstanding in order to participate in the RI Health Professional Loan Repayment Program.

My signature below authorizes the release of my credit report to RI Higher Education Assistance Authority.

Participants Name (print)

Date

SECTION 3. Employer Information Forms

EMPLOYER HEALTHCARE ORGANIZATION

Name of Employer Healthcare Organization

Name of Applicant (health professional)

Employer address

City

State

Zip Code

Employer contact name

Title

Employer phone

Fax

Employer contact email

HEALTHCARE ORGANIZATION EMPLOYER QUALIFICATIONS*

TYPE OF SHORTAGE DESIGNATION

Primary Care Dental Mental Health Other: _____

HPSA # / MUA #

HPSA Score

Date of Effective HPSA Score

*Shortage designation information can be found here: <http://www.hrsa.gov/shortage/find.html>

SITE TYPE

Federally Qualified Health Center Hospital Licensed Health Center Community Based Mental Health
 Public Sector (Corrections) Private Practice (Solo or Group) For Profit
 Other

HEALTH PROFESSIONAL QUALIFICATIONS

Provide the following information describing the unique healthcare needs this health provider can address at your organization.

How will this healthcare professional serve the community? Specify the type of patients and/or populations he/she will care for. Examples could include, but are not limited to, homeless, elderly, LGBTQQ.

Please indicate: # of hours of direct outpatient care _____ # of hours of non patient care duties _____

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Payor Mix Information Form

HAVE YOUR BILLING OR FINANCIAL STAFF PROVIDE THE FOLLOWING PATIENT PAYOR MIX PERCENTAGE.

PERCENTAGE OF PATIENT POPULATION

Medicaid (Rite Care) %

Medicaid / Medicare Dual Eligible %

Self Pay %

Medicare %

Other Uninsured %

PLEASE TELL US WHERE THE ABOVE DATA WAS DERIVED, AND THE TIME PERIOD IT REPRESENTS.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

Signature

Date

Print Name and Title

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PROVIDE ASSURANCE OF EMPLOYER ELIGIBILITY CRITERIA BY INITIALING THE FOLLOWING ITEMS AS APPROPRIATE:

STATEMENT	AFFIRMATION (INITIALS)
Health professional applicant will provide services in a public or a non-profit organization that holds any necessary Rhode Island Department of Health licenses.	
The employer healthcare organization (and billing entity if different) is licensed as a provider by the Rhode Island Department of Health and complies with all relevant regulations, accepts Medicare, and accepts patients enrolled in Medicaid.	
The employer healthcare organization (and billing entity if different) is in compliance (good standing) with the Rhode Island Department of Health and is located in a Health Professional Shortage Area (HPSA).	
The employer healthcare organization operates full time with hours designed to meet the needs of the community (such as late afternoon, evening, weekend, or early morning hours), and either provides directly or has formal contractual arrangements for after-hour, weekend, and holiday urgent, emergency, and acute care.	
The employer healthcare organization must provide documentation of fee schedule or sliding fee scale and policy (attach documents to the application).	
The employer healthcare organization agrees to provide primary care services to any individual seeking care. RI HPLRP awardees and employer (and practice site, if different) must agree not to discriminate on the basis of the patient's ability to pay for such care or on the basis that payment for such care will be made pursuant to Medicaid, Medicare, the RIte Care Health Insurance Program, and/or through the sliding fee scale.	
The employer of RI HPLRP awardees agrees to schedule a site visit with staff and provide information to verify recipient's work hours, vacation time and related information to the RI HPLRP.	
As a representative of (employer healthcare organization):	
I recommend this applicant for the RI HPLRP. Comments if any:	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	
Signature	Date
Print Name and Title	
DECLARATION: THIS DECLARATION MUST BE SIGNED BY THE EMPLOYER HEALTHCARE ORGANIZATION REPRESENTATIVE.	
The applicant employer healthcare organization certifies that it meets the eligibility requirements and has provided truthful information regarding the employment of the applicant and is in compliance with all specifications set forth by the Rhode Island Health Professional Loan Repayment Program (RI HPLRP) for Health Professionals Request for Responses. The employer healthcare organization certifies that loan repayment funds will not be used to supplant an RI HPLRP provider's expected wages or benefits as compared to other similarly qualified and situated employees.	
SIGNATURE OF AUTHORIZED REPRESENTATIVE	
Signature	Date
Print Name and Title	

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