Rhode Island Health Professionals Loan Repayment Program
2023 Application Supporting Documents

Applicant Name **Date**

DOCUMENT CHECKLIST FOR HEALTH PROFESSIONALS

This checklist has been provided to facilitate the application process. To be considered for a loan repayment award, you must complete the online applications and submit the following supporting documents in the list below, unless otherwise indicated. Please print documents on one side only and do not staple.

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

Please check off each applicable item. **Your completed** *Document Checklist* **should be submitted with your Supporting documents.** All supporting documents should be submitted in the order that they appear on the checklist. Keep a copy of your submission for your records.

SECTION 1: Online Application

- ☐ The 2023 HPLRP Online Application can be found on:
  https://surveys.health.ri.gov/redcap/surveys/?s=CJWTWDP77A

SECTION 2: Required supporting documents from the health professional:

- ☐ Copy of the health professional's current resume or curriculum vitae (maximum of 5 pages)
- ☐ Copy of the health professional's current Rhode Island professional license
- ☐ Proof of US citizenship (provide a copy of passport or birth certificate)
- ☐ Health professional's qualifying loan statement(s)
  - ☐ Please provide student loan balance(s) and account information from your lenders
- ☐ W-9 (Verification of Taxation Reporting Information)
  Download at https://www.irs.gov/pub/irs-pdf/fw9.pdf
- ☐ Paystub from your practice site(s) from the month prior to, or the month of, the application deadline
- ☐ Credit Authorization and Privacy Disclosure Form
- ☐ If applicable:
  - ☐ Copy of DATA 2000 waiver
  - ☐ Documentation of certification by the International Certification and Reciprocity Consortium (C and RC) or the Association for Addiction Professionals (NAADAC) to provide substance abuse services

SECTION 3: Required forms and supporting documents from employer/ practice site

- ☐ Employer Information Form completed and signed by the authorized 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)
- ☐ Payor Mix Information Form completed and signed by an authorized representative
- ☐ A copy of the sliding-fee scale and policy of the practice site. The sliding-fee scale should reflect current National Health Service Corps (NHSC) guidelines. More information can be found on:
  https://bphc.hrsa.gov/programrequirements/compliancemanual/chapter-9.html
- ☐ Employer Eligibility Attestation
  FOR EMPLOYER FORMS, PLEASE SUBMIT ORIGINALS WITH SIGNATURES

Mail to: ATTN: Rebeca Vasquez / Manuel Ortiz
Office of Primary Care and Rural Health
Rhode Island Department of Health
3 Capitol Hill, Room 410
Providence, RI 02908

Online applications & supporting documents must be delivered or postmarked by February 10, 2023.

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 that your application be discussed during open session.

APPLICATIONS MISSING ANY INFORMATION WILL NOT BE REVIEWED.

Credit Report Authorization and Privacy Disclosure Form

I hereby authorize and instruct the Division of Higher Education Assistance (DHEA) to obtain and review my credit report. My credit report will be obtained from Experian reporting agency chosen by DHEA. I understand and agree that DHEA 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 the Division of Higher Education Assistance.

Participants Signature_____

Participant's Name (print)_____

Date:_____

Correspondence Address: 560 Jefferson Blvd., Warwick, RI 02886 • (401) 736-1100 • FAX (401) 732-3541
www.riheaa.org TDD 734-9481 www.collegeboundfund

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SECTION 3 of 3. Employer Information Form

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

TYPE OF SHORTAGE DESIGNATION*

☐ **Primary Care** ☐ **Dental** ☐ **Mental Health**

HPSA ID: _____ HPSA Score (for reporting purposes only): _____

*Shortage designation information can be found here: http://data.hrsa.gov/tools/shortage-area/hpsa-find

SITE TYPE

☐Federally Qualified Health Center ☐Hospital licensed health center ☐Public Sector

☐Community-based mental health ☐Private practice (individual or group) ☐For-profit

Other_____

Please provide the following documents with this form:

☐Copy of non-profit or not-for-profit documentation for the healthcare organization or practice site.

☐A copy of your organization's sliding-fee scale and policy of practice site. The Sliding-fee scale should reflect current National HealthService Corps (NHSC) guidelines.

☐A copy of your organization's retention plan.

SPECIAL SERVICES AND POPULATIONS SERVED

Please select any HHS priorities addressed by the healthcare organization:

☐ COVID-19-related services ☐ Integrated behavioral health services in a primary care setting ☐ Opioid use treatment services ☐ Medication Assisted Treatment (MAT) for OUD ☐Substance use treatment services ☐ Telehealth services ☐ Maternal health services ☐None of the above

Please select any/all vulnerable populations that are served by the healthcare organization:

☐ Children or Adolescents ☐ Older adults ☐ Individuals experiencing homelessness ☐ Individuals with HIV/AIDS ☐ Lesbian/Gay/Bisexual/Transgender ☐ Low-income persons/families ☐ People with disabilities ☐ Pregnant women and infants ☐ Refugee Adults ☐ Tribal Populations ☐ Undocumented Immigrants ☐ Unemployed ☐ Uninsured/Underinsured persons/families ☐ Veterans ☐Other: _____

Are there any Partners/Consortia that the organization uses to offer training? If so, who? _____

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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	(NHPRI, United RIte Care, Tufts, Medicaid)	%
Medicare	(traditional or Advantage plans)	%
Dual eligible	(People with both Medicare *and* Medicaid)	%
Uninsured	(Self-pay or Sliding-scale)	%
Commercial	(Blue Cross, United, Tufts, others)	%

PLEASE TELL US THE SOURCE OF THE ABOVE DATA, AND THE TIME PERIOD IT REPRESENTS.

SIGNATURE OF AUTHORIZED REPRESENTATIVE

Signature Date

Print Name and Title

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Employer Eligibility Attestation

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

STATEMENT	AFFIRMATION (INITIALS)
The health professional applicant will provide services in a public or a non-profit organization that holds any necessary Rhode Island Department of Health (RIDOH) licenses.	
The employer healthcare organization (and billing entity if different) is licensed as a provider by RIDOH 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 RIDOH 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 providesdirectly, or has formal contractual arrangements for, after-hour, weekend, and holiday urgent, emergency, and acute care.	
The employer healthcare organization has a documented 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. Rhode Island Health Professional Loan Repayment Program (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, theRIte Care Health Insurance Program, and/or through the sliding-fee scale.	
The employer of Rhode Island 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 Rhode Island HPLRP.	
As a representative of (employer healthcare organization), I recommend this applicant for the Rhode Island HPLRP	
Comments/Recommendations about this applicant, 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's 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 (HPLRP) for Health Professionals Request for Responses. The employer healthcare organization certifies that loan repayment funds will not be used to supplant a 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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Letter of Confirmation of Employment

TO BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE FROM THE HEALTHCARE ORGANIZATION

Please attach a letter to this form that confirms the applicant's employment status within your healthcare organization. The letter will also be used to confirm certain information provided by the applicant. Please use letterhead and have the letter signed by whomever the agency deems appropriate. The Human Resources contact listed in the application is acceptable.

This is NOT a letter of recommendation. Space to comment on the applicant is available on page 5 under the Employer Eligibility Attestation heading.

The following information should be included in the letter:

- ☐ Provider Name
- ☐ Functional job title (descriptive of the provider's responsibilities)
    - For example, Nurse Care Manager rather than Registered Nurse
- ☐ Site name and address (include all sites if more than one)
- ☐ Provider's FTE (weekly)
- ☐ Provider's hours of direct, outpatient care (weekly)
- ☐ Provider's hours of non-patient care (weekly; include administrative, teaching, and research hours)

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