2021 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 each item on 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 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 (preferably typed) and signed by the applicant
- ☐ Copy of the health professional's current resume or curriculum vitae
- ☐ Copy of the health professional's current Rhode Island professional license
- ☐ Documentation of certification by the International Certification and Reciprocity Consortium (CandRC) or the Association for Addiction Professionals (NAADAC) to provide substance abuse services–IF APPLICABLE
- ☐ Copy of DATA 2000 waiver–IF APPLICABLE
- ☐ Proof of US citizenship (provide a copy of passport or birth certificate)
- ☐ Typed essay (500 words maximum)
- ☐ Health Professional Eligibility Attestation

SECTION 2. Financial Forms

- ☐ *Permission to Verify Loan Balances* form completed and signed by the applicant
- ☐ Health professional's qualifying loan statement(s) https://nslds.ed.gov/nslds/nslds_SA/
- ☐ Pay stub from practice site from the month prior to, or month of, application
- ☐ *Credit Authorization and Privacy Disclosure Form*
- ☐ W-9 (Verification of Taxation Reporting Information) Download at http://www.irs.gov/pub/irs-pdf/fw9.pdf

SECTION 3. Employer Forms

- ☐ *Employer Information Form,* completed and signed by 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)
- ☐ A copy of sliding-fee scale and policy of practice site; Sliding-fee scale should reflect current National Health Service Corps (NHSC) guidelines https://nhsc.hrsa.gov/downloads/nhsc-sites/nhsc-sliding-fee-discount-program.pdf
- ☐ *Payor Mix Information Form* completed and signed by authorized representative
- ☐ Employer Eligibility Attestation
- ☐ Submit Originals with Signatures

Keep a copy of the entire application for your records.

Mail to: Margaret Gradie, PhD
Department of Health – Office of Primary Care and Rural Health
3 Capitol Hill, Room 410
Providence, RI 02908

Applications must be delivered or postmarked by March 1, 2021, at 5 p.m.

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.

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SECTION 1 of 3. Health Professional Information Form

PERSONAL INFORMATION

First name | Last name | Middle Initial

Home address | Date of Birth

City | State | ZIP code | Country

Home phone | Work phone

Email (Please use one email consistently)

Residence prior to health professional education

City | State | ZIP code | Country

Gender ☐ M ☐ F ☐ Other ☐ Decline to answer

Are you of Hispanic, Latino, or Spanish origin?

☐ Yes ☐ No ☐ Don't know/Not sure ☐ Decline to answer

Which one of the following would you say is your race? (Check one.)

☐ American Indian/Alaskan Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other ☐ Decline to answer

☐ I am applying as a full-time service provider working **40 hours** (with no more than eight hours per week of teaching or practice-related administrative activities) per week at a Health Professional Shortage Area (HPSA) site for a **two year** service commitment.

☐ I am applying as a half-time service provider working **20-39 hours** (with no more than four hours per week of teaching or practice-related administrative activities) per week at a HPSA site for a **four 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 (DDS or DMD)
☐ DH Dental Hygienist
☐ Physician Doctor (MD or DO)
☐ HSP Psychologist (PhD or EdD)
☐ L(I)CSW Licensed Clinical Social Worker (master's/doctoral degree in social work)
☐ MFT Marriage and Family Therapist (master's/doctoral degree with a major study in marriage and 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
☐ Master's level substance use counselor

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PROFESSIONAL INFORMATION (continued)

Specialty: (e.g. Family Medicine)

Current License # License Expiration Date NPI

Board certified? ☐ Yes ☐ No ☐ Not Applicable

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 one 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 Rhode Island HPLRP?

☐ Yes ☐ No If Yes, date of previous award_____

Do you provide substance abuse services (i.e. counseling) at your site?

☐ Yes ☐ No

Are you certified by the International Certification and Reciprocity Consortium (C&RC) or the Association for Addiction Professionals (NAADAC) to provide substance abuse services?

☐ Yes ☐ No If yes, please provide documentation.

Do you possess a DATA 2000 waiver?

☐ Yes ☐ No If yes, please provide documentation.

Will you have a substance abuse training or certification completed?

(Please refer to the program web page for a list of acceptable trainings.)

☐ Yes ☐ No If Yes, date of completion_____

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

Please indicate whether you have a current commitment to any of the following study loan repayment programs and, if so, the **date your obligation ends**. (Please add other commitments on a separate page and include it with the application.)

National Health Service Corps	☐ Yes	☐ No	End date:_____
RISLA Nursing Rewards	☐ Yes	☐ No	End date:_____
Nurse Corps	☐ Yes	☐ No	End date:_____
RISLA Primary Care Loan Repayment	☐ Yes	☐ No	End date:_____
Loan Repayment for Dental Professionals	☐ Yes	☐ No	End date:_____
Other_____	☐ Yes	☐ No	End date:_____

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PROFESSIONAL INFORMATION (continued)

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 Rhode Island HPLRP?

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

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Please Answer the Following Questions:

1. In addition to English, what language(s) do you speak with sufficient fluency to provide adequate healthcare? Please rate your proficiency as beginner, intermediate or advanced. (Example: Spanish – beginner)

   _____

2. In addition to English, what language(s) do you speak but NOT with sufficient fluency to provide adequate healthcare?

   _____

3. What translation services are offered by your practice (check all that apply):

   ☐ On-site certified medical translation staff
   ☐ Telephonic translation services
   ☐ Video translation services
   ☐ Services for the deaf

4. I know how to access the language assistance services at my practice (check one).

   ☐ Yes ☐ No

5. I am able to greet my non-English speaking patients in their native language(s) (check one).

   ☐ Yes ☐ No

6. I am able to provide my non-English speaking patients with appropriate materials in their language(s) (check one).

   ☐ Yes ☐ No

7. I have completed Culturally and Linguistically Appropriate Services (CLAS) training (check one).

   ☐ Yes ☐ No

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Essay

CHOOSE ONE OF THE TWO ESSAYS

CLEARLY INDICATE WHICH ESSAY QUESTION YOU ARE ANSWERING. Essay should be no more than 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 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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Healthcare Professional Eligibility Attestation

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, a state, or other entity, that will not be completely satisfied before the Rhode Island 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, and 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 Rhode Island 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 (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 Rhode Island HPLRP program description. By signing this application, I agree to all of the conditions stipulated in the Rhode Island HPLRP program description.

SIGNATURE OF HEALTH PROFESSIONAL APPLICANT

Signature _____ Date _____

Print Name and Title _____

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SECTION 2 of 3. 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 Division of Higher Education Authority of the Rhode Island Office of the Postsecondary Commissioner (DHEA of RIOPC), any information about loans requested by DHEA. This information is for the use of DHEA 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:
DHEA of RIOPC
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)

STUDENT LOAN INFORMATION

Please attach a copy of your student loan statement(s) (https://nslds.ed.gov/nslds/nslds_SA/) 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 the balance of each outstanding loan. Below please list each student loan dollar amount. Amount awarded by the Rhode Island HPLRP will not exceed total loan amount.

	Current total loan balance (required) $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
Student loan carrier	
Account Number	Current balance of loan $
What is your current total annual salary?	$
What is the amount you are requesting from the Rhode Island 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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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_____

Participants 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 ☐ Community based mental health
☐ Public sector ☐ Private practice (individual or group) ☐ For profit
☐ Other_____

Please provide:

☐ Copy of non-profit or not-for-profit documentation for the helathcare employer organization or practice site

☐ A copy of sliding-fee scale and policy of practice site; Sliding-fee scale should reflect current National Health Service Corps (NHSC) guidelines

☐ A copy of retention plan

(Please refer to the program website for a list of organizations for which these documents are on file and need not be submitted)

LETTER OF CONFIRMATION OF EMPLOYMENT

Please attach a letter Section 3 of the application that confirms the applicant's employment status. The letter will also be used to confirm certain information provided by the applicant. Please use letterhead and have 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 12 under the Employer Eligibility Attestation heading.

The following information should be included:

- 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 FTE (weekly)
- Providers hours of direct, outpatient care (weekly)
- Provider hours of non-patient care (weekly; include administrative, teaching and research hours)

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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)
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 provides directly, 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, the RIte 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 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 (HPLRP) for Health Professionals Request for Responses. The employer healthcare organization certifies that loan repayment funds will not be used to supplant a 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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