National Health Service Corps/State Loan Repayment Program
Primary Care Health Professional Application

Instructions for Submitting an Application

- Applications are currently being accepted through October 1, 2010.

- Before submitting an application, please speak with the Human Resources unit or Recruiter at your prospective site to ensure that they are willing to participate in the program and support your application submission.

- The current application form must be used for submission. The form title includes the current grant period. Please go to www.oshpd.ca.gov/HWDD/SLRP.html to access the most current application.

- The following documents **MUST BE** submitted in order for an application package to be considered complete:
    1. Completed Application;
    2. Personal Statements, Part D of the application;
    3. Certification of Practice Site, Part G of the application;
    4. A letter of recommendation from the practice site; and
    5. Educational Debt Reporting Form, Part F of the application;
    6. Copy of current lender statements (dated within one month of application submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name, current balance, account number, and the mailing address of the lender.
    7. Copy of current license or certification

- Mail application package to: OSHPD/HWDD
State Loan Repayment Program
400 R Street, Suite 330
Sacramento, CA 95811

- Notification of award will be sent out within 4-6 weeks of the final filing date (October 1, 2010). Please read the application instructions very carefully.

- Make sure that your practice site has submitted a Certified Eligible Site Application. If you need a copy of the application, please go to www.oshpd.ca.gov/HWDD/SLRP.html. You may also refer to our website to see a current list of the Certified Eligible Sites which have previously submitted an application. Under the "Looking for Employment" section, click on the link for the specialty which you are providing services for.

- If you would like assistance to determine whether or not your facility is located in a Health Professional Shortage Area, please contact our Shortage Designation Program at (916) 326-3700.

If you have questions regarding the application or eligibility, please e-mail the Program Administrator via e-mail at SLRP@oshpd.ca.gov or via telephone at (916) 326-3700.

NHSC/State Loan Repayment Program
Primary Care Health Professional Application

2010/2011 Grant Period

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application. Applications will be accepted from August 1-October 1, 2010. Please note that this application is only good for the 2010/2011 grant period.

PART A: PERSONAL INFORMATION

Applicant's Name: ______________________________

Mailing Address: ______________________________

City: ____________ **County**: ____________ **State**: ______ **Zip**: ________

Phone Numbers (provide at least 2): (____)________________ Hm ☐ Wk ☐ Cell ☐

(____)________________ Hm ☐ Wk ☐ Cell ☐

(____)________________ Hm ☐ Wk ☐ Cell ☐

E-mail address (provide at least 1): ______________________ Wk ☐ Personal ☐

______________________ Wk ☐ Personal ☐

Social Security Number: ______________ **CA Drivers License/ID:** ______________

Date of Birth: ______________ **Gender:** Male ☐ Female ☐

Race/Ethnicity:

American Indian or Alaska Native ☐
Asian ☐
Black or African American ☐
Other* ☐
Hispanic or Latino ☐
Native Hawaiian or Other Pacific Islander ☐
White or Caucasian ☐

*Please specify: ______________________________

List languages you speak, read, and or write in addition to English (check all that apply):

1. ____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐
2. ____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐
3. ____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐

For Official Use Only:

Application Rec'd: ____________ Postmark Date: ____________ Reviewed by: ____________

Application: Complete ☐ Incomplete ☐ Ineligible ☐ Applicant cleared by: NHSC ☐ HPEF ☐

Practice Site: On File ☐ Site Type: 330 ☐ RHC ☐ FQHC/LAL ☐ CHC ☐ County Clinic ☐

Other: ______________________________

MSSA Type: Urban ☐ Rural ☐ Frontier ☐ State Region: Northern ☐ Central ☐ Southern ☐

PC ☐ MH ☐ DC ☐ HPSA ID # ________________ HPSA Score ________ AD ☐

PC ☐ MH ☐ DC ☐ HPSA ID # ________________ HPSA Score ________ AD ☐

Comments:

PART B: QUALIFICATIONS AND ELIGIBLITY

1. **Are you a United States citizen?** Yes ☐ No ☐
2. **Do you have a current and unrestricted California license to practice your profession?** Yes ☐ No ☐
3. **Do you owe an existing service obligation to another entity?** Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)
4. **Are you free of judgments arising from Federal debt?** Yes ☐ No ☐
   (If no, please provide explanation in your personal statements, Part D of this application)
5. **Are you delinquent with any court ordered child support?** Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of this application)
6. **Did you apply for the NHSC Federal Loan Repayment Program?** Yes ☐ No ☐
   If yes, please indicate the date of submission: _____________________

PART C: HEALTH PROFESSION INFORMATION

MD ☐ DO ☐
(Indicate primary specialty)
Family Physician ☐
General Internist ☐
General Pediatrician ☐
Obstetrician-Gynecologist ☐
General Psychiatrist ☐
Gerontology ☐

Physician Assistant ☐
Nurse Practitioner ☐
Certified Nurse-Midwife ☐
Dentist (D.D.S) ☐
Dentist (D.M.D) ☐
Dental Hygienist ☐

Clinical/Counseling Psychologist ☐
Licensed Clinical Social Worker ☐
Mental Health Counselor ☐
Licensed Professional Counselor ☐
Marriage and Family Therapist ☐
Psychiatric Nurse Specialist ☐

School:____ Date of Graduation: ____________________

City: ____ State: _________ Zip: ________________

Postgraduate Training: ____________________________________ Year Completed: ______________________

Board Eligible: ☐ Board Certified: ☐ California License Number: _________________________________

Certificate Number: ____

PART D: PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed and at least one-page in length. Restate and number each question along with your answer.

1. Describe the types of training or work experience you have had in a medical, dental, or mental health professional shortage area.
2. Describe any cultural competency training and/or life experience you may have (include number of units completed in college or CME).
3. Why do you want to participate in the NHSC/State Loan Repayment Program?
4. If applicable, explanations for questions answered in Part B of this application.

Part E: QUESTIONNAIRE (optional)

1. Where did you hear about California's NHSC/State Loan Repayment Program? (check all that apply)
   - ☐ Work (employer/co-worker)
   - ☐ Family member, Friend, or Acquaintance
   - ☐ State Loan Repayment Program Website
   - ☐ NHSC Website
   - ☐ Other Website (please specify) ______________________________
   - ☐ Organization or Affiliation (please specify)______________________________
   - ☐ Other Source (please specify) ______________________________

2. Where did you receive the California NHSC/State Loan Repayment Program application form?
   - ☐ Work (employer/co-worker)
   - ☐ Family member, Friend, or Acquaintance
   - ☐ State Loan Repayment Program Website
   - ☐ State Loan Repayment Program Office
   - ☐ Other Source (please specify) ______________________________

PART F: EDUCATIONAL DEBT REPORTING

DIRECTIONS:

- **List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be complete even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete and it will not be reviewed.**
- **You must submit evidence of the educational debts listed below. If your loans have been consolidated, submit proof of consolidation.**
- **Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted.) Online printouts are acceptable as long as they include all of the required information.**
- **You may only submit proof of debt for those loans obtained during the course of your undergraduate or graduate education which led to your current license/certification as a qualified provider for this program. Make sure that the Lender Address listed below corresponds with the address to which payments are sent to. This address must also appear on the lender statements you have included in your application packet.**

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1. Lender Name: ____

Lender Address (send payments to): ____

City: ______________________ **State:** __________ **Zip +4:** ______________

Account Number: ______________________ **Current Loan Balance $** ______________

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2. Lender Name: ____

Lender Address (send payments to): ____

City: ______________________ **State:** __________ **Zip +4:** ______________

Account Number: ______________________ **Current Loan Balance $** ______________

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3. Lender Name: ____

Lender Address (send payments to): ____

City: ______________________ **State:** __________ **Zip +4:** ______________

Account Number: ______________________ **Current Loan Balance $** ______________

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4. Lender Name: ____

Lender Address (send payments to): ____

City: ______________________ **State:** __________ **Zip +4:** ______________

Account Number: ______________________ **Current Loan Balance $** ______________

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5. Lender Name: ____

Lender Address (send payments to): ____

City: ______________________ **State:** __________ **Zip +4:** ______________

Account Number: ______________________ **Current Loan Balance $** ______________

PART G: CERTIFICATION OF PRACTICE SITE (to be filled out by the practice site)

The completed form must bear an original ink signature and be returned with the provider's application. Photocopies and faxed copies of the completed form are not acceptable.

In addition to this form, please provide a letter of recommendation stating why this applicant is a good candidate for the State Loan Repayment Program.

PRACTICE SITE INFORMATION

Please list the actual street address of the practice setting(s) where the applicant is working, or has entered into an agreement to provide services, full-time 40 hrs/wk (including a minimum of 32 hours of direct patient care).

*** Practice Site:** ____ **Percentage of time:** ________

Address: ____

City: __________________________ **County:** __________________ **Zip +4:** __________

Practice Site Contact Person: ____

Title: ________________________________ **Telephone Number:** (____) _________________

*** Practice Site:**____ **Percentage of time:** ________

Address: ____

City: ______________________________ **County:** ________________ **Zip +4:** __________

Practice Site Contact Person: ____

Title: ________________________________ **Telephone Number:** (____) ________________

MEMORANDUM OF UNDERSTANDING (MOU) INFORMATION

Please provide the name of the clinic or parent agency that will enter into a memorandum of understanding with the Office of Statewide Health Planning and Development.

Clinic or Parent Agency:____

Address: ____

City: __________________________ **County:** __________________ **Zip +4:** __________

Contact Person (person who will sign MOU):____

Title: _________________________________ **Telephone Number:** (______) _______________

I certify that the practice site or parent agency will pay the applicant prevailing wages and agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

I certify that the practice site and/or parent agency will pay half the award amount not to exceed $25,000 for the first two years of committed service.

I declare under penalty of perjury that these statements are true and correct.

Name:________________________________ **Title:** ______________________________

Signature: ____________________________ **Date:** ______________________________

Telephone Number: (____) ___________________ **E-mail:** ____________________________

PART H: APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum two years of full-time practice. I authorize representatives of the Office of Statewide Health Planning and Development to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application.

Signature: ____ **Date:** ___________________

Submission Check List:

- ☐ **Completed Application**
- ☐ **Personal Statements**
- ☐ **Certification of Practice Site**
- ☐ **Letter of Recommendation from Practice Site**
- ☐ **Educational Debt Reporting Form**
- ☐ **Current Lender Statements**
- ☐ **Copy of Current License or Certification**

Submit application and required documents to:

OSHPD/HWDD
State Loan Repayment Program
400 R Street, Suite 330
Sacramento, CA 95811