Health Care Professional Application

For more information: http://www.kdheks.gov/olrh/FundLoan.html
Email questions to: kdhe.primarycare@ks.gov

Health Care Professional Name: ________________________________ Discipline: _____________
Health Care Practice Site: _____________________________________________________________________

Please read the Kansas State Loan Repayment Program (SLRP) Overview and Application Guidance and Frequently Asked Questions documents in their entirety before completing this application or submitting questions regarding the SLRP. The application and attachments must be complete, typed or printed legibly, and submitted between June 1 and July 31 of the application year. No early or late applications will be accepted. An incomplete application will be deemed ineligible.

If the health care professional works at multiple practice sites, each practice site must complete a separate Health Care Practice Site Application form.
ATTACHMENTS THAT MUST BE INCLUDED WITH APPLICATION

The following documents must be included with the SLRP application. Failure to submit these documents will result in the application being incomplete and ineligible. All attachments should include the health care professional and practice site name at the top of each page and be labeled as Attachment # or PS Attachment #.

☐ Attachment 1  Proof of US Citizenship or US National (birth certificate, ID page of passport, or naturalized citizenship certificate) **driver’s license and social security card are NOT acceptable proof of citizenship**

☐ Attachment 2  Proof of Kansas professional license

☐ Attachment 3  Eligible student loan documentation

☐ Attachment 4  Personal statement of health care professional

☐ Attachment 5  Completed Health Care Practice Site Application form for each practice site **with** supporting practice site attachments

The following attachments are to be completed and attached to the Health Care Practice Site Application.

☐ PS Attachment 1  completed Health Care Practice Site Application form for each practice site

☐ PS Attachment 2  copy of health care professional’s job description and employment contract

☐ PS Attachment 3  practice site policy on non-discrimination of patients based upon race, color, sex, national origin, disability, religion, age or sexual orientation

☐ PS Attachment 4  practice site policy for the sliding fee scale discount or financial assistance, and the patient application form for financial assistance

☐ PS Attachment 5  photograph of posted signage of the non-discrimination policy and sliding fee scale/financial assistance policy

☐ PS Attachment 6  practice site proof of access/referral arrangements for ancillary, inpatient and specialty care that is not available on-site (MOUs, MOA, or contracts) If formal referral arrangements do not exist, describe how the practice site assures patient access to this care:

_______________________________________________________________________

_______________________________________________________________________

☐ PS Attachment 7  recruitment and retention plan and proposal to retain the health care professional upon completion of the service obligation

☐ PS Attachment 8  completed Federal W-9 form
Health Care Professional Name: __________________________________________ Discipline: _____________

NPI#: ____________________ License#: ______________ SS#: __________________ Date of Birth: ________

Home Street Address: _____________________________________________________________________

City: ___________________________________________ State: _________  Zip: _______________ +________

Phone: __________________________  Email: ______________________________________________

How did you learn about the SLRP? ______________________________________________________________
_______________________________________________________________________________________

Demographics (for federal reporting purposes only)

Gender:  □ Male  □ Female  Race/Ethnicity:  □ Caucasian  □ African-American
           □ Hispanic/Latino  □ Native American  □ Asian  □ Pacific Islander
           □ Other

From the tables below, check the appropriate discipline and list the specialty for the health care professional:

- Primary Health Care:  □ MD  □ DO  □ PA  □ APRN/NP  □ CNM
  Specialty: ____________________________________________________________________

- Dental Health Care:  □ DDS  □ DMD  □ RDH  
  Specialty: ____________________________________________________________________

- Mental Health Care:  □ MD  □ DO  □ APRN/NP  □ PA  □ HSP  □ LCSW
  □ LMAC  □ LMSW  □ LPC  □ MFT  □ PNS
  Specialty: ____________________________________________________________________

□ Yes  □ No  Are you under any service obligation with any entity that you agreed to serve for a specific period of time in a particular area or practice site (such as an employment sign-on bonus)?
If yes, explain: ___________________________________________________________________

□ Yes  □ No  Have you ever been a National Health Service Corps (NHSC) or other federal service program recipient?
If yes, explain: ___________________________________________________________________

□ Yes  □ No  Are you currently a National Health Service Corps (NHSC) or other federal service program recipient?
If yes, which program? __________________________________________________________________

□ Yes  □ No  Have you ever applied for and been denied a National Health Service Corps (NHSC) or other federal service program?
If yes, which program? __________________________________________________________________
When did you apply and were denied? __________________________________________________________________

□ Yes  □ No  If practicing in an area with a HPSA score 18 or higher, have you applied for the National Health Service Corps Loan Repayment Program (NHSC LRP) this year?
If not, why? ___________________________________________________________________
HEALTH CARE PROFESSIONAL EDUCATION

Complete this section on education toward the profession you are currently practicing in.

Undergraduate school: ________________________________________________________________
City: ______________________________________ State: ________________________
Degree: _________________________________ Date: ______________

Graduate/Professional school: __________________________________________________________
City: ______________________________________ State: ________________________
Degree: _________________________________ Date: ______________
Residency site (if applicable): __________________________________________________________
City: ______________________________________ State: ________________________
Degree: _________________________________ Date: ______________

HEALTH CARE PRACTICE SITE INFORMATION

You are responsible to ensure that each practice site location that you provide direct patient care services completes the SLRP Health Care Practice Site Application form and include that form and all attachments with the application packet. List each practice site information below. Use as many additional pages as needed, add your name and practice site name to top of each page.

Health Care Practice Site 1:
Practice Site Name: __________________________________________________________________
Address: __________________________________ City: ________________________ KS Zip: ______++____
Medical/Dental Director: __________________________________________________________________
Primary Point of Contact: __________________________________________________________________
Phone: _______________________ Email: ________________________________________________
Date of Employment: ____________ Hours worked per week: ____ Hours providing direct patient care: ____

Health Care Practice Site 2 (if applicable):
Practice Site Name: __________________________________________________________________
Address: __________________________________ City: ________________________ KS Zip: ______++____
Medical/Dental Director: __________________________________________________________________
Primary Point of Contact: __________________________________________________________________
Phone: _______________________ Email: ________________________________________________
Date of Employment: ____________ Hours worked per week: ____ Hours providing direct patient care: ____

HEALTH CARE PROFESSIONAL LOAN INFORMATION

Complete the following information for each outstanding educational loan received to support undergraduate or graduate education that led to the completion of your current professional training and licensure. If any eligible loan
is consolidated or refinanced with a non-educational loan, no portion of the consolidated/refinanced loan is eligible for loan repayment.

☐ Yes  ☐ No  Have you ever defaulted on a personal or student loan? If yes, date of default: ________________

☐ Yes  ☐ No  Were any personal or student loans ever under a federal court judgement? If yes, date of judgement: ________________

☐ Yes  ☐ No  Have you ever filed for bankruptcy? If yes, when: ________________

Complete the following table for each loan marked LOAN 1, LOAN 2, LOAN 3, etc., Add as many extra pages as needed with your name and practice site name on the top of each additional page. The following documentation must be included for each eligible loan to be considered for the SLRP:

- copy of the original loan application and agreement;
- promissory note;
- disclosure statement;
- current account statement dated within 30 days of SLRP application; and
- statement from the current loan holder indicating:
  - borrower's name;
  - original amount borrowed;
  - current loan balance;
  - monthly payment;
  - date of disbursement; and
  - type of loan.

**Loan Summary Table** (list all eligible student loans)

<table>
<thead>
<tr>
<th>LOAN #</th>
<th>ACCOUNT #</th>
<th>ACADEMIC PERIOD</th>
<th>ORIGINAL AMOUNT</th>
<th>ORIGINAL DATE</th>
<th>CURRENT BALANCE</th>
<th>CURRENT BALANCE DATE</th>
<th>MONTHLY PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOAN 1</td>
<td></td>
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<td>LOAN 2</td>
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<tr>
<td>LOAN 3</td>
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<td>LOAN 4</td>
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<td>LOAN 5</td>
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<tr>
<td>LOAN 6</td>
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<td>LOAN 7</td>
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<td>LOAN 8</td>
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<td>TOTAL</td>
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</tr>
</tbody>
</table>
LOAN 1 (corresponds to Loan 1 in above chart)
Lending institution name: ____________________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): __________________
Purpose of the loan listed on loan application: __________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:
Secondary lending institution name: ______________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Monthly payment due: _____________________________

LOAN 2 (corresponds to Loan 2 in above chart)
Lending institution name: ____________________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): __________________
Purpose of the loan listed on loan application: __________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:
Secondary lending institution name: ______________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Monthly payment due: _____________________________

LOAN 3 (corresponds to Loan 3 in above chart)
Lending institution name: ____________________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): __________________
Purpose of the loan listed on loan application: __________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:
Secondary lending institution name: ______________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Monthly payment due: _____________________________

LOAN 4 (corresponds to Loan 4 in above chart)
Lending institution name: ____________________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): __________________
Purpose of the loan listed on loan application: __________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:
Secondary lending institution name: ______________________________________________________
Address: __________________________ City: __________________ State: ______ Zip: __________
Loan account no.: __________________ Monthly payment due: _____________________________
LOAN 5 (corresponds to Loan 5 in above chart)

Lending institution name: ________________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): ______________________
Purpose of the loan listed on loan application: _________________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:

Secondary lending institution name: _________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Monthly payment due: __________________

LOAN 6 (corresponds to Loan 6 in above chart)

Lending institution name: ________________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): ______________________
Purpose of the loan listed on loan application: _________________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:

Secondary lending institution name: _________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Monthly payment due: __________________

LOAN 7 (corresponds to Loan 7 in above chart)

Lending institution name: ________________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): ______________________
Purpose of the loan listed on loan application: _________________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:

Secondary lending institution name: _________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Monthly payment due: __________________

LOAN 8 (corresponds to Loan 8 in above chart)

Lending institution name: ________________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Type of loan (e.g., GSL, NDSL, HEAL): ______________________
Purpose of the loan listed on loan application: _________________________________________________
☐ Yes ☐ No Is this a consolidated loan? ☐ Yes ☐ No Was the loan sold? If the loan was sold:

Secondary lending institution name: _________________________________________________________
Address: __________________________________ City: __________________ State: ______ Zip: ____________
Loan account no.: __________________ Monthly payment due: __________________
HEALTH CARE PROFESSIONAL PERSONAL STATEMENT

Answer the following questions in the format of a personal statement, labeled asAttachment 4 with your name and practice site name at top of each page. Personal statement must be typed and no longer than three pages in length.

1. Describe experience or training in multicultural settings or serving populations with special needs.

2. Describe experience or familiarity in a rural or undeserved area.

3. Describe reasons for choosing a rural or underserved community for practice and considerations involved in the decision.

4. Describe how you, as a health care professional, will work to address the growing opioid abuse epidemic and steps you will take to address it in your community.

5. Describe your long-term goals and commitment to your practice site, including factors that influenced your decision to choose the community and practice site.

6. Describe the patient population to which you provide or will provide services and how you, as a health care professional, will address these disparities and/or improve the health outcomes of the patient population.

HEALTH CARE PROFESSIONAL APPLICATION SIGNATURE

I have read and understand the Overview and Guidance Document which describes the requirements of the Kansas State Loan Repayment Program (SLRP) and affirm that I meet the qualifications for participation in the program. I authorize the Kansas Department of Health and Environment (KDHE) to contact the listed employing health care practice site(s) and relevant licensing authorities for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification and providing willfully false information will result in disqualification from the SLRP.

I certify that the information provided is accurate and complete to the best of my knowledge.

_________________________________________________  ________________________
Printed Name of Health Care Professional     Date

Signature of Health Care Professional

_________________________________________________  ________________________
Printed Name of Authorized Practice Site Representative   Date

Signature of Authorized Practice Site Representative

Submit all documents to:
State Loan Repayment Program
Office of Primary Care and Rural Health
Bureau of Community Health Systems
1000 SW Jackson St, Suite 340
Topeka KS 66612-1365
Phone: 785-296-3135
KANSAS STATE LOAN REPAYMENT PROGRAM

Health Care Professional Eligibility Attestation

For more information: http://www.kdheks.gov/olrh/FundLoan.html
Email questions to: kdhe.primarycare@ks.gov

Health Care Professional Name: _________________________________________ Discipline: ____________
Health Care Practice Site: _____________________________________________________________________

This form must be completed by the health care professional applying for loan repayment assistance from the Kansas State Loan Repayment Program (SLRP). **This form must be notarized.**

I hereby confirm that have read and understand the Overview and Application Guidance document and meet the established criteria for the Kansas State Loan Repayment Program (SLRP) and:

- have no existing service obligations that will not be completed by July 31 of the SLRP application year;
- have never been convicted of, or pled guilty to, a felony as defined under federal or state law;
- have not defaulted on any educational loans or filed federal bankruptcy;
- have no judgment liens against personal property for a debt to the United States or the State of Kansas;
- have never defaulted on any federal payment obligations (HEAL, Nursing Student Loans, federal income tax liability, FHA loans, etc.);
- have never breached a prior service obligation to the federal/state/local government or other entity, even if the obligation has been subsequently satisfied; and
- have not had any federal debt written off as uncollectible or had any federal service or payment obligation waived.

I certify that the information provided is accurate and complete to the best of my knowledge.

_________________________________________________  ________________________
Printed Name of Health Care Professional     Date

_________________________________________________
Signature of Health Care Professional

Subscribed and sworn to before me this Notary Seal

__________ day of __________________________ 20_____.

_________________________________________________
Notary Signature

Submit all documents to:
State Loan Repayment Program
Office of Primary Care & Rural Health
Bureau of Community Health Systems
1000 SW Jackson St, Suite 340
Topeka KS 66612-1365
Phone: 785-296-3135