KANSAS STATE LOAN REPAYMENT PROGRAM

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 PERSONAL INFORMATION

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 ☐ Hispanic/Latino ☐ Asian ☐ Other ☐ African-American ☐ Native American ☐ Pacific Islander

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)

LOAN #	ACCOUNT #	ACADEMIC PERIOD	ORIGINAL AMOUNT	ORIGINAL DATE	CURRENT BALANCE	CURRENT BALANCE DATE	MONTHLY PAYMENT
LOAN 1							
LOAN 2							
LOAN 3							
LOAN 4							
LOAN 5							
LOAN 6							
LOAN 7							
LOAN 8							
TOTAL							

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 as Attachment 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