KANSAS STATE LOAN REPAYMENT PROGRAM

Health Care Professional Loan Payment Verification

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: _____

The State Loan Repayment Program (SLRP) will disburse the SLRP contract funds directly to the health care practice site. It is the practice site's responsibility to deposit the SLRP funds into the practice site account and then submit payment of the total amount of funds to the health care professional or the lender(s) listed on the health care professional's application. Funds must be forwarded to the health care professional or lender(s) within 30 days after the practice site received the funds.

The SLRP funds are to be used as an annual one-time payment toward eligible student loans and do not replace regularly scheduled loan payments. The health care professional is solely responsible to use the SLRP funds as payment to the loan holder(s) as listed on the SLRP application. The loan payments must be completed within 90 days of the disbursement of funds by the KDHE to the practice site. The health care professional is responsible to submit the *Health Care Professional Loan Payment Verification* form to the KDHE within 120 days of the funds being allocated to the practice site. Failure to submit documentation of payment of the entire amount of the SLRP award or failure to provide this form or any of the information requested on this form may result in default of the contract.

Provide a summary of loan payments made during the contract year for all eligible loans. Attach as many pages as needed, add your name and practice site name to the top of each additional page.

LOAN 1

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 2

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 3

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

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LOAN 4

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 5

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 6

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 7

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

LOAN 8

Lending institution name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Loan account no.: _____

Total SLRP funds paid: $ _____ SLRP payment date: _____

Loan balance: $_____ Date of loan balance: _____

TOTAL AMOUNT PAID

Total amount SLRP contract funds paid toward eligible loans listed on the application: $_____

Along with this form, include a copy of the most recent statement from each loan servicer showing:

- health care professional name;
- loan account number;
- payment record of SLRP funds; and

- current loan balance.

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

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