REQUIRED SUPPORTING DOCUMENTATION FOR THE NEW HAMPSHIRE STATE LOAN REPAYMENT (SLRP) APPLICATION

No application will be considered unless all questionnaires are completed and supporting documents are submitted in a timely manner. "**Received Date" is a level of priority; applications will not be considered received until they are complete. Applications documentation must be submitted in the following order:**

- **Applicant Questionnaire**
- **Completed Alternate W-9 Form**
  - Applicant's information, NOT employer's. Instructions are included and should be strictly followed.
- **Employer Questionnaire**
  - It will be your responsibility to make sure this portion of the application is completed along with the required documents and submitted on a timely basis. The employer may provide the employer information sheet and the required copy of the "discounted sliding-fee scale" directly to the Rural Health and Primary Care Section but you must note that with your application submission
- **Provide current resume (1 copy)**
  - Must have current employer and practice site(s) listed
- **Copy of most recent New Hampshire Medical License; showing the expiration date (1 copy). Behavioral Health providers under supervision toward licensure must provide an *Employer Confirmation of Supervision* form (can be found under the Applications and Forms link).**
- **Proof of citizenship or naturalization (1 copy)**
  - Acceptable documentation: Birth Certificate, Baptismal certificate, hospital birth records, US Passport, Alien Registration Card, Naturalization Certificate, any form of work eligibility documentation defined by USCIS, Native American Tribal Documents, DD Form 214. Do NOT submit a drivers license or Soc. Security card.
- **Copies of all outstanding medical, behavioral, and/or dental educational loan balances.** Documentation must include your name and/or account number with reference to your name
- **On a separate sheet of paper**
  - Describe your training and experience working with the vulnerable populations in New Hampshire. Please include health disparities and describe how you, and the practice site, are trying to address these disparities. Include any other information that would be helpful in assessing your qualifications, the community needs, and the practice site needs. If this is a new position or you have worked less than two years at this practice site, please explain why you are committed to working in a medically underserved area and your short- and long-term plans to continue your service in New Hampshire
- **IMPORTANT:** It will be the responsibility of the applicant and/or the facility to seek out non-federal matching funds. The benefit of matched contracts means that the application will be given priority and the applicant will not have to compete against any other applicant if qualified for the program. The State encourages a match because it shows an investment in primary health care, mental health and oral health care by the employer. Even a partial match is helpful in maximizing our state resources. The applicants without any match are scored and compete for state funding with a larger group of qualified applicants, if funding is available. Make sure your employer/HR office has the proper information in regards to your application request

- It is also important you read and understand the certification statement at the end of your application before you sign and notarize.

- Applications must be received in paper form via mail (you may scan/email a **complete**, notarized copy as well) and:

  - **Applications should be printed single-sided and with documentation in the order listed above**
  - **Do not use staples, binders, or pages larger or smaller than 8.5 x 11**

- **Please return completed application to:**
  N.H. Division of Public Health Services
  Rural Health & Primary Care Section
  29 Hazen Drive, 2E,
  Concord, NH 03301-6504
  You may email a COMPLETE scanned copy to: SLRP@dhhs.nh.gov. The original still must be mailed to us.

If you have any questions, please e-mail the State Loan Repayment Program at: SLRP@dhhs.nh.gov

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM APPLICATION

Applicant Questionnaire

- Loan Repayment Contract Terms begin July 1st, October 1st, January 1st and April 1st during the State's fiscal year (July 1st thru June 30th). The first payment is paid in the first month of the following quarter, and quarterly thereafter for the duration of the contract. Applicants are responsible for submitting complete applications. Application packages will be initially reviewed to determine their completeness. Application packages deemed incomplete as of the application deadline will not be considered for funding for that contract term.

START HERE - Please type or print in black ink.

Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Primary/Work E-mail: _____

Work Phone: _____ Work Fax:_____ Secondary/Personal Email: _____

National Provider Identifier (NPI): _____ Sex: Male ☐ Female ☐

DOB:_____

- U.S. Citizen or U.S. National? ☐ YES ☐ NO

- Please check your discipline:

Tier 1	Tier 2	Tier 3
☐ MD	☐ PA	☐ RDH
☐ DO	☐ PA-Hospitalist	☐ LADC
☐ General Surgeon	☐ APRN	☐ Primary Care (only) RN
☐ MD/DO-Hospitalist	☐ APRN-Hospitalist	
☐ Psychiatrist	☐ CNM	
☐ DMD	☐ PsyD	
☐ DDS	☐ PsychNP	
	☐ MHC	
	☐ CSW	
	☐ MFT	
	☐ MLADC	
	☐ Behavioral Health under supervision	

- Are you licensed in New Hampshire? ☐ YES ☐ NO
  If no, when do you plan to receive your license (or approximate)? (month/year) _____/_____

- Length of employment at current facility: Years: ____ Months: ____
  Salary/Wage: _____

  If unemployed, beginning date of new employment (month/day/year): _____
  Salary/Wage: _____

- Are you currently working for an eligible NH Department of Health and Human Services funded program? ☐ Yes ☐ No
  If yes, please provide the name of the program: _____

- Are you considered: ☐ Full-Time ☐ Part-Time (SLRP determines whether your status for your contract will be F/T or P/T.)
- Maximum hours do you work in a week? _____
- Maximum hours that you work in a week providing **outpatient** direct patient care: _____ (Be specific – not a span of hours)
- Maximum hours providing clinical services in alternate settings (e.g. hospitals, schools, shelters): _____ (Please note the location)
- Maximum hours that you work in a week providing administrative duties: _____ (Be specific – not a span of hours)
- How many days per week do you work? _____
- How many hours per day do you work in a regular week? _____
- Hours spent teaching or on research during a regular work week: _____
- Do you speak another language other than English in your clinical practice? ☐ YES ☐ NO If yes,

☐ French	☐ Chinese	☐ Hindi	☐ Arabic
☐ Spanish	☐ German	☐ Italian	☐ American Sign Language
☐ Portuguese	☐ Greek	☐ Russian	☐ Other _____

- The practice site is located in which federal designed shortage area? (check one) ☐ HPSA ☐ MHPSA ☐ DHPSA ☐ MUA ☐ MUP ☐ EMUP ☐ Non-designated

Go here to find out whether your practice site is in a federal designated shortage area:

Primary Practice Site: _____

Site Address: _____

City: _____ State: _____ Zip: _____ County: _____

Work Phone: _____ Fax #: _____

Hours spent in outpatient direct patient care: ____

Hours spent in clinical services at an alternate setting: ____

Hours spent in administration: ____

Secondary Practice Site: _____

Site Address: _____

City: _____ State: _____ Zip: _____ County: _____

Work Phone: _____ Fax #: _____

Hours spent in outpatient direct patient care: ____

Hours spent in clinical services at an alternating setting: ____

Hours spent in administration: ____

Name of Employer if different from Primary Practice Site: _____

Employer Address: _____

City: _____ State: _____ Zip: _____ County: _____

Work Phone: _____ Fax #: _____

HR Manager/Representative for Application process and quarterly reports:_____ Title: _____
Phone #: _____ E-mail: _____
(This person will be the contact for quarterly verifications by the State to determine provider contract compliance.)

- Do you agree to charge for services at the usual and customary rates prevailing in the primary care service area, with the exception of patients unable to pay the usual and customary rates who shall be charged – according to the service site's sliding-fee-schedule and based on poverty level - a reduced rate or no charge at all? ☐ YES ☐ NO

- Do you agree not to discriminate on the patient's ability to pay for care or the payment source, including Medicare and Medicaid? ☐ YES ☐ NO

- Do you have any outstanding contractual obligations for health services to the:
  - Active Military? ☐ YES ☐ NO
  - National Guard? ☐ YES ☐ NO
  - National Health Service Corps Loan Repayment Program (NHSC LRP)? ☐ YES ☐ NO
  - NHSC Scholarship Program? ☐ YES ☐ NO
  - Nurse Education Loan Repayment Program (NELRP)? ☐ YES ☐ NO
  - Nursing Scholarship Program? ☐ YES ☐ NO
  - State or other entity? ☐ YES ☐ NO

  If yes to any above, when will the service obligation be completely satisfied? _____

Answering yes to any of the questions below requires that an **explanation be attached** to the application.

- Do you have a judgment lien against your property for a debt to the United States? ☐ YES ☐ NO
- Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? ☐ YES ☐ NO
- Has your medical/certification license ever been suspended or revoked in any state? ☐ YES ☐ NO
  If yes, when? _____
  Reason for suspension/revocation: _____
- Are any professional disciplinary actions against you pending in any state? ☐ YES ☐ NO
  If yes, date of disciplinary action (month/year): _____/_____
  Reason: _____
- Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws? ☐ YES ☐ NO
- Do you have a judgment lien against your property for a debt to the United States? ☐ YES ☐ NO
- Are you delinquent in childcare payments in any State? ☐ YES ☐ NO
  If yes, please explain: _____

LOAN EXPENSES FOR MEDICAL PROFESSIONAL EDUCATION THAT ARE OUTSTANDING

*Attach copies of all outstanding medical and/or dental educational loan balances from the month previous to, or month of, this application. Copies of education loan balances not received will not be considered. Please be especially diligent when completing this section; filling in each loan then the total of the loans. Those marked "Attached" will be deemed incomplete causing delay.

Lender Name	Account #	Original Amt. of Loan	Current Balance Due	Balance Due Date	Monthly Payment
	Total				

Amount you are requesting from the State Loan Repayment Program: $_____

Note: Please provide this information to your employer so that they know what amount of matching funds might be needed. See information on website for possible loan repayments for part- and full-time health care providers.

If your service site is located in a Health Professional Shortage Area (HPSA), Mental Health Shortage Area (MHPSA), or a Dental Health Shortage Area (DHPSA) in NH, have you applied for federal loan repayment (should be done before State Loan Repayment) for this year? ☐ YES ☐ NO If yes, was it approved? ☐ YES ☐ NO ☐ Pending Decision (If "pending" you must wait until a decision is received to apply for SLRP. If denied please provide a copy of the notification from NHSC.)

- Where did you hear about the State Loan Repayment Program?

☐ School ☐ Employer ☐ Co-Worker ☐ Internet ☐ State website ☐ Other_____

CERTIFICATION BY APPLICANT

(Notary Required)

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in immediate disqualification from participation in this program. Any person who knowingly makes a false statement or misrepresentation in this loan application repayment transaction, fraudulently obtains repayment for a loan, or commits any other legal action in connection with this transaction is subject to repaying any amount received from this program, plus interest. Once a contract is signed, any person who, through the legal contract, commits to serve and fails to complete the period of obligated services shall be liable to the State of New Hampshire for an amount equal to the sum of the total amount paid to them under the contract as well as an unserved obligation penalty in an amount equal to 20% of the total contract amount paid out. S/he shall also forfeit any remaining allotments under that contract. This entails making a legal commitment to serve for three years (or two years for part-time) at the stated practice site. I have read this statement and understand its contents. I am also declaring that I have read and understand the SLRP Policies and Guidelines.

Applicant Signature:_____ Date: _____
Must be signed on date of notarization

Witness: _____ Date: _____
Notary Public or Justice of the Peace

SEAL

ALTERNATE W-9

INSTRUCTIONS

Please complete ALL sections of the Alternate W-9 form. If any section is left blank, the form will be returned and direct payment to you may be delayed. **This form must include YOUR PERSONAL information, not your employer's information!**

Please complete the name and address portion of the form **as you wish to have payments made**.

LEGAL ENTITY NAME

This is **YOUR** name; the name to whom checks will be made payable. It must be the name that matches the taxpayer identification number (Your SS#) indicated on the form.

PAYMENT ADDRESS and CITY/STATE/ZIP

This is **your home address** - the address to which checks will be mailed.

BUSINESS ADDRESS and CITY/STATE/ZIP

"Same" as you're considered the business receiving the payments. **Do not put your work address**.

SOCIAL SECURITY NUMBER / NUMBER USED ON IRS TAX RETURN

This number should be that which is assigned to the legal name indicated on the W-9 form. Be sure to fill in all 9 digits. Social Security # is required to participate in the State Loan Repayment Program.

MISCELLANEOUS

Please complete the form by printing or typing in your name and title (if applicable), signature, date, and telephone number where you may be reached during the weekday. This information should be accurate and legible in the event that we need to contact you for clarification or additional information.

Please complete the Alternate W-9 Form and submit with your applicant questionnaire application.

STATE OF NEW HAMPSHIRE
ALTERNATE W-9 FORM

PLEASE USE THIS FORM TO PROVIDE THE REQUESTED INFORMATION

VENDOR # _____
(Assigned by Purchase & Property)

Pursuant to IRS Regulations, you must furnish your Taxpayer Identification Number (TIN) to the State whether or not you are required to file tax returns. If this number is not provided, you may be subject to a 24% withholding on each payment made to you. To avoid this 24% withholding & to ensure that accurate tax information is reported to the IRS, A RESPONSE IS REQUIRED.

Legal Entity Name: _____

Doing Business As Name: _____

Payment Address: _____

City/Town: _____ STATE: _____ ZIP: _____ COUNTRY:_____

Business Address: _____

City/Town: _____ STATE: _____ ZIP: _____ COUNTRY:_____

Telephone #: _____ Cell Phone #: _____ FAX #: _____

Contact Person: _____ Website:_____ E-Mail (Main Office):_____

TAXPAYER IDENTIFICATION NUMBER (TIN) as used on IRS tax return

Social Security # (SSN): _____ Fed ID # (EIN/FIN): [redacted]

PRINCIPAL ACTIVITY

[redacted] Service Provider [redacted] Product/Merchandise Provider [X] Other Provider

List the principal type of service, product or other that is provided: **State Loan Repayment Program**

[redacted] Medical/Health Care Services [redacted] Legal Services [redacted] 1099 Grant Reportable

DESIGNATION (select ONLY THOSE which apply to you/your organization as provided to the IRS)

[X]	Individual/Sole-Proprietor Single Member LLC	[redacted]	Corporation (S)	[redacted]	Government
[redacted]	LLC (C Corporation)	[redacted]	Corporation (C)	[redacted]	Travel/Intern
[redacted]	LLC (S Corporation)	[redacted]	Partnership	[X]	Refund/Reimbursement
[redacted]	LLC (P Partnership)	[redacted]	Estate or Trust	[redacted]	Tax-Exempt

EXEMPTIONS: [redacted] Exemption from FATCA reporting: [redacted]

Under penalty of perjury, I declare that the information provided is true, correct & complete, to the best of my knowledge & belief.

NAME & TITLE (print or type): _____

TELEPHONE #: _____CELL PHONE #:_____FAX #: _____

SIGNATURE:_____DATE: _____

E-Mail (Main Office):_____Website:_____

PLEASE RETURN WHEN COMPLETED TO:

SLRP@dhhs.nh.gov

STATE LOAN REPAYMENT PROGRAM
RURAL HEALTH AND PRIMARY CARE SECTION
29 HAZEN DRIVE
CONCORD, NH 03301

New Hampshire State Loan Repayment Program (SLRP)
(Employer Questionnaire)

Please print or type and respond to all questions.

APPLICANT INFORMATION

- Name of Loan Repayment Applicant: _____
  Last First
- Applicant's discipline at Practice Site: _____
- Practice Site Name(s): _____
- Is this applicant considered full-time or part-time with the employer and/or practice site? ☐ F/T ☐ P/T (Behavioral Health providers under supervision are only eligible if full-time)
- If applicant is a General Surgeon or Hospitalist is he/she employed by a Critical Access Hospital in New Hampshire? ☐ YES ☐ NO ☐ N/A
- Does this applicant have a current and unrestricted NH License/Certification to practice in New Hampshire? ☐ YES ☐ NO If no, please explain: _____
- Is this applicant requesting loan repayment for retention efforts? ☐ YES ☐ NO
- How long have they been employed at the practice site? Years: ____ Months: ____ Salary/Wage: _____
- Does the applicant have a current contract/employment agreement with the employer? ☐ YES ☐ NO
  Contract/employment agreement expires on: _____/_____/_____
- How many hours per week do you expect the applicant to work in outpatient care setting at the approved practice site(s) during normally scheduled office hours? _____Hrs.
- How many hours per week do you expect the applicant to provide clinical services in alternate settings (e.g., hospitals, school, shelters) as directed by the approved practice site(s)? ____Hrs. Where?
- How many hours per week do you expect the applicant to provide practice related administrative duties? _____Hrs.
- Is this applicant going to perform any teaching or research duties while employed at this practice site during the week? ☐ NO ☐ YES How many hours out of week: ____Hrs.
- Is this applicant's employment contingent on obtaining state loan repayment? ☐ YES ☐ NO
  If yes, please explain: _____

EMPLOYER INFORMATION

Name of Employer Organization: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

HR Manager/Director: _____ Title: _____

E-Mail _____Ph:(_____)_____Ext. _____Fax: _____

CEO/President/Exc. Director of Organization: _____ Title: _____

Email: _____

- Type of Practice: (please check one)
  - ☐ Fed. Qualified Health Center (FQHC)
  - ☐ DPHS Funded Clinical Health Center
  - ☐ Rural Health Clinic
  - ☐ Critical Access Hospital
  - ☐ NH DHHS funded program
  - ☐ Dental Clinic
  - ☐ Community Mental Health Center
  - ☐ Substance Abuse Disorder Treatment Center
  - ☐ Public, Not For Profit
  - ☐ Private, For Profit
  - ☐ Other _____

  - Please provide the name of the NH DHHS funded program(s):
    _____
    Contract Expiration Date(s): _____

  - Is there a discounted sliding-to-fee-schedule in place, including free care at the practice site(s)? ☐ YES ☐ NO
    If no, what does the practice site offer for discounted rates? _____

  - Is it posted in Waiting Room? ☐ YES ☐ NO

    If not posted, is it available at receptionist/administration desk for the public to view? ☐ YES ☐ NO
    If No, how is it available to patients? _____
    This is a required document for consideration for a State Loan Repayment. **Please provide copy of a Sliding-Fee-Scale that a customer would receive for financial consideration.**

  - Do you accept all patients regardless of method of payment, including Medicaid/Medicare assignment, and ability to pay? ☐ Yes ☐ No If No, explain: _____

  - Is there any limit on the number of patients seen by the applicant & practice site(s) in regards to the uninsured or underinsured patients? ☐ YES ☐ NO If yes, explain: _____

  - Is there any limit on the number of patients seen by the applicant & practice site(s) in regards to Medicare and Medicaid patients? ☐ YES ☐ NO If yes, explain: _____

  - Describe your payor mix in the last 6 months as % of revenue at the practice site at which the applicant will or has been employed. (Must be completed for scoring of application)

    Uninsured: _____%

    Medicaid: _____%

    Medicare: _____%

    Commercial: _____%

    Other: _____%

The NH State Loan Repayment Program gives higher priority to applications for which 50% employer matching funds are available, as this leverages state funds to meet the needs of more underserved areas. The state and local matching funds will be paid out over the term of the contract. In addition, applicants employed full-time will be given higher priority than applicants who are employed part-time. After all priority applicants have been awarded contracts, the applicants without any match are scored based on program priorities and compete for state funding with a larger group of qualified applicants, if funding is available.

The employer needs to discuss with the applicant the amount of outstanding educational loans that they are trying to pay off. See the State Loan Repayment Program website for possible loan repayments that the State awards to a participant.

- Has the applicant discussed this loan repayment application with Human Resources? ☐ Yes ☐ No

- If this applicant is awarded a state loan repayment contract with the State, has your employer and/or community budgeted funds to match 50% of the award amount for the loan repayment? ☐ Yes ☐ No Amount: _____

  If no, will the employer know when available funds will become available? _____
  Person to contact: _____ Ph: _____Ext.: _____

- If unable to provide 50% of the matching funds, has the employer and/or community budgeted funds to provide a partial match of the award each year of the contract? ☐ Yes ☐ No Amount: _____per year
  Person to contact: _____ Phone: _____Ext: ____

- **Required with employer portion of the application:**

1. ☐ A copy of the Employer's Sliding-Fee-Scale and policy/procedures.
2. ☐ A written statement describing any extenuating circumstances or hardship needs if the employer and/or community is unable to provide any type of matching funds for this applicant seeking a State Loan Repayment.

☐ As the facility's authorized representative, I have read the NH State Loan Repayment Program Guidelines and understand the employer requirements in regards to the forthcoming Memorandum of Agreement, should a contract be awarded.

Print Contact Name: _____Title:_____
Facility's Authorized Representative

Signature: _____Date: _____
Facility's Authorized Representative

- If you wish not to provide the Employer's Questionnaire to the applicant please send to:

  N.H Division of Public Health Services
  Rural Health & Primary Care Section
  29 Hazen Drive, 2E
  Concord, NH 03301-6504

Please inform the applicant if you've sent the employer's questionnaire and documentation directly to Rural Health & Primary Care. Thank you.

If you have any questions, please email the State Loan Repayment Program at SLRP@dhhs.nh.gov.