REQUIRED SUPPORTING DOCUMENTATION FOR THE NH STATE LOAN REPAYMENT (SLRP)
CONTINUATION APPLICATION

No application will be considered unless all questionnaires are completed and supporting documents are submitted in a timely manner. **These documents must show that they've been updated since initial submission.**

- **Provide current resume (1 copy)**
  - Must have current employer and practice site(s) listed
- **Proof of most recent New Hampshire Medical License or Certification for eligibility (1 copy)**
- **Copies of all outstanding educational loan balances**
- **On a separate sheet of paper**
  - Please explain how past loan repayment loan awards have contributed to reducing your educational debt and have helped you serve the underserved population of New Hampshire
- **Attach a completed 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 questionnaire and the required copy of the "discounted sliding-fee scale" directly to the Rural Health and Primary Care Section
- **Important:** It will be the responsibility of the applicant and/or the facility/community to seek out non-federal matching funds. The benefit of matched contracts means that 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 and/or community. 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.

- **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

  If you have any questions, please e-mail Rural Health & Primary Care at: SLRP@dhhs.nh.gov

  To learn more about the State Loan Repayment Program you may go to our web site at:
  http://www.dhhs.nh.gov/dphs/bchs/rhpc/repayment.htm

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM
APPLICATION FOR CONTINUATION OF CONTRACT
Applicant Questionnaire

- Continuation involves amendment of your current contract and needs to be completed and approved by Governor and Council before your current contract expires. Applications will be initially reviewed to determine their completeness and MUST be submitted 6 months prior to expiration.

START HERE - Please type or print in black ink.

Name: _____
Last First Middle

Mailing Address: _____

City: _____ State: _____ Zip: _____

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

Work Phone: _____ Work Fax:_____ Secondary/Work 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	

- Is your New Hampshire license soon-to-expire? ☐ YES ☐ NO month/year _____/_____ (Governor and Council will not approve an extension with a license expiring just before G&C approval/extension date)
- Length of employment at current facility: Years: ____ Months: ____
  Salary/Wage: _____
- Are you considered: ☐ Full-Time ☐ Part-Time (must be the same status you were contracted for)
- How many maximum hours do you work in a week? _____

- Maximum hours that you work in a week providing **outpatient** direct patient care: _____. (SLRP determines whether your status for your contract will be F/T or P/T.)

- Maximum hours providing clinical services in alternative settings (e.g. hospitals, schools, shelters) as directed by the approved service site(s): _____

- Maximum hours that you work in a week providing administrative duties: _____

- How many days per week do you work? _____

- How many hours per day do you work in a regular week? _____

- Time spent on-call during 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 alternating 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	Payment 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 denied please provide a copy of the notification from NHSC.)

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, agrees 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. I have read this statement and understand its contents.

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

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

SEAL

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM
APPLICATION FOR CONTINUATION OF CONTRACT
(Employer Questionnaire)

The Rural Health & Primary Care Section will accept three (3) applications in one state fiscal calendar year from an employer. If more than one (1) application is submitted during a contract term the employer will need to prioritize which health care provider is needed the most.

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
- How long 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 service site(s) during normally scheduled office hours? _____Hrs.
- 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.

EMPLOYER INFORMATION

Name of Employer Organization: _____

Street Address: _____

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

Contact Person HR: _____ Title: _____

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

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

- Type of Practice: (please check one)
  - ☐ Fed. Qualified Health Center (FQHC)
  - ☐ DPHS Funded Clinical Health Center
  - ☐ Rural Health Clinic
  - ☐ Critical Access Hospital
  - ☐ NHDHHS 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 Program(s) which is contracted with NH Health and Human Services (if applicable):
    _____
    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 & service 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 & service 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 that the applicant will or has been employed. (Must be completed for scoring of application)

  Uninsured: _____% Commercial: _____%

  Medicaid: _____% Other: _____%

  Medicare: _____%

The NH State Loan Repayment Program gives higher priority to applications for which 50% employer and/or community matching funds are available as this leverages state funds to meet the needs of more communities. 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 State Web site 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: _____
  Person to contact: _____ Phone: _____Ext: ____

- **Documents 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.

  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 email or mail 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 mailed or faxed the employer's questionnaire and documentation directly to Rural Health & Primary Care. Thank you.

If you have any questions, please email Rural Health & Primary Care at SLRP@dhhs.nh.gov