

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.

- **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)**
- **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
- **Copies of all outstanding medical, behavioral, and/or dental educational loan balances**
- **Completed Alternate W-9 Form**
 - Applicant's information, NOT employer's. Also, social security number is required
- **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
- **Attach a completed Employer Questionnaire Sheet.** 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
- **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 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 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.
- Applications must be received in paper form via mail (attached to email is not acceptable) and:
 - **Applications should be printed single-sided**
 - **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

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
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: _____	Preferred/Work E-mail: _____
Work Phone: _____	Work Fax: _____	Secondary/Work Email: _____
National Provider Identifier (NPI): _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	
	DOB: _____	

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

- Please check your discipline and provide specialty:

Discipline: Tier 1 MD DO Gen. Surgeon Psychiatrist DDS DMD
Tier 2 PA APRN CNM CP PNS MHC CSW MFT LPC MLADC
Tier 3 RDH LADC

Specialty: _____

- Are you licensed in New Hampshire? YES NO

If no, when do you plan to receive your license? (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

- How many maximum hours do you work in a week? _____

- Maximum hours that you work in a week providing outpatient direct patient care: _____

- Maximum hours providing clinical services in alternative settings (e.g. hospitals, nursing homes, 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: _____
- Estimated hours directly serving patients when on-call, in a 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,

<input type="checkbox"/> French	<input type="checkbox"/> Chinese	<input type="checkbox"/> Hindi	<input type="checkbox"/> Arabic
<input type="checkbox"/> Spanish	<input type="checkbox"/> German	<input type="checkbox"/> Italian	<input type="checkbox"/> American Sign Language
<input type="checkbox"/> Portuguese	<input type="checkbox"/> Greek	<input type="checkbox"/> Russian	<input type="checkbox"/> Other _____
- The practice site is located in which federal designated shortage area? (check one) HPSA MHPSA DHPSA MUA
 MUP EMUP Non-designated

Follow link to find out whether your service site is in a federal designated shortage area:
<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>

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: _____

Hours spent on-call: _____

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: _____

Hours spent on-call: _____

Name of Employer if different from Primary Practice Site: _____

Employer Address: _____

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

Work Phone: _____ Fax #: _____

HR Manager/Contact Person for Loan Repayment Application: _____ 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 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 Web-Site 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.

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

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.

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

BUSINESS 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.

PRINCIPAL ACTIVITY

You are an "Other Provider" and where you are asked to list "Principal type of service" please list your credentials/specialty.

Provider: Physician, Dentist, Physician Assistant, Dental Hygienists, Advanced Practice Registered Nurse, Nurse-Midwife, Clinical or Counseling Psych., Psychiatric Nurse, Mental Health Counselor, Lic. Prof. Counselor, Marriage or Family Therapists, Alcohol and Drug Counselor, General Surgeon

DESIGNATION

You are an "Individual" applying for State Loan Repayment. Do not check any other boxes.

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 W-9 Alternate 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 28% withholding on each payment made to you. To avoid this 28% withholding & to ensure that accurate tax information is reported to the IRS, A RESPONSE IS REQUIRED.

**If a service provider is a part of a GROUP PRACTICE, it is the group name & TIN which is required on this Alternate W-9.
If the service provider is a SOLE PROPRIETOR, it is the individual name & TIN which is required on this Alternate W-9.**

BUSINESS NAME: _____

Doing Business as Name: _____

PAYMENT ADDRESS: _____

CITY/TOWN: _____ **STATE:** _____ **ZIP:** _____

BUSINESS ADDRESS: _____

CITY/TOWN: _____ **STATE:** _____ **ZIP:** _____

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

Social Security # (SSN): _____ **Fed ID # (EIN/FIN):**

PRINCIPAL ACTIVITY

Service Provider Product/Merchandise Provider Other Provider

List the principal type of service, product, or other that is provided: **SLRP-** _____

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

Individual/Sole-Proprietor Corporation (S) Government
 LLC (C Corporation) Corporation (C) Medical or Health Care Services
 LLC (S Corporation) Partnership Legal Services
 LLC (P Partnership) Estate or Trust Non-Profit

EXEMPTIONS: Exemption from FATCA reporting:

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:** _____

WEBSITE: _____ **EMAIL (Main Office):** _____

PLEASE RETURN WHEN COMPLETED TO:

**DIVISION OF PUBLIC HEALTH SERVICES
RURAL HEALTH AND PRIMARY CARE SECTION
29 HAZEN DRIVE
CONCORD, NH 03301**

EMPLOYER INFORMATION

Name of Employer Organization: _____

Street Address: _____

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

HR Manager: _____ Title: _____

E-Mail _____ Ph:(_____) _____ Ext. _____ Fax: _____

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

▪ Type of Practice: (please check one)

- | | |
|--|--|
| <input type="checkbox"/> Fed. Qualified Health Center (FQHC) | <input type="checkbox"/> Community Mental Health Center |
| <input type="checkbox"/> DPHS Funded Clinical Health Center | <input type="checkbox"/> Substance Abuse Disorder Treatment Center |
| <input type="checkbox"/> Rural Health Clinic | <input type="checkbox"/> Public, Not For Profit |
| <input type="checkbox"/> Critical Access Hospital | <input type="checkbox"/> Private, For Profit |
| <input type="checkbox"/> NHDHHS funded program | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Dental Clinic | |

▪ Please provide the name of the Program(s) which is contracted with NH Health and Human Services:

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: _____ 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 at <http://www.dhhs.nh.gov/dphs/bchs/rhpc/documents/slrpguidelines.pdf> 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 mail or fax 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.