REQUIRED SUPPORTING DOCUMENTATION FOR THE NEW HAMPSHIRE PRIVATE PRACTICE DENTISTS STATE LOAN REPAYMENT (SLRP-PPD) APPLICATION

No application will be considered unless complete 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.**

- **Applicant Questionnaire (most recent version available on the website)**
- **Completed Alternate W-9 Form**
  - Applicant's information, NOT employer's. Instructions are included and should be strictly followed.
- **Employer Questionnaire Sheet**
  - It will be your responsibility to make sure this portion of the application is completed and submitted on a timely basis.
- **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**
- **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 is also important you read and understand the certification statement at the end of your application before you sign and notarize.

- Complete applications must be scanned and emailed (after notarization) to SLRP@dhhs.nh.gov and hard copies also mailed by the deadline:

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

- **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:
  https://www.dhhs.nh.gov/programs-services/health-care/rural-health-primary-care/state-loan-repayment-program-slrp

NH PRIVATE PRACTICE DENTISTS STATE LOAN REPAYMENT PROGRAM APPLICATION

Applicant Questionnaire

- Private Practice Dentists Loan Repayment Contract Terms begin quarterly, according to the contract start date. The first payment is paid in the first month after the first quarter of service, and quarterly thereafter for the duration of the contract. State Fiscal Year quarters run Jul-Sept, Oct-Dec, Jan-Mar, Apr-Jun. 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): _____ Gender: Male ☐ Female ☐

DOB:_____

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

- Please check your discipline: ☐ DDS ☐ DMD

- Are you licensed in New Hampshire? ☐ YES ☐ NO

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

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

- 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 _____

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/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 understand you must provide services to a minimum of 15% Medicaid patients each quarter? ☐ YES ☐ NO

- Do you have any outstanding contractual obligations for health services to the:
  - Active Military? ☐ YES ☐ NO
  - National Guard? ☐ 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 DENTAL PROFESSIONAL EDUCATION THAT ARE OUTSTANDING

*Attach copies of all outstanding 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: $_____

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 administration fee. 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 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. **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

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

SLRP - RURAL HEALTH AND PRIMARY CARE SECTION
29 Hazen Drive, Concord, NH 03301

NH Private Practice Dentists State Loan Repayment Program Application
(Employer Questionnaire)

Please print or type and respond to all questions.

APPLICANT INFORMATION

- Name of Loan Repayment Applicant: _____
  Last First
- Practice Site Name(s): _____
- 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 a loan repayment for retention efforts? ☐ YES ☐ NO
- 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: _____/_____/_____
- 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: _____ Title: _____

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

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

E-Mail _____

OPTIONAL MATCHING FUNDS INFORMATION

- Has the applicant discussed this loan repayment application with their employer? ☐ Yes ☐ No
- If this applicant is awarded a state loan repayment contract with the State, has your employer budgeted funds to match 50% of the award amount for the loan repayment? ☐ Yes ☐ No Amount: _____
- If providing other than 50% in matching funds, has the employer budgeted funds to provide a partial match of the award each year of the contract? ☐ Yes ☐ No Amount: _____per year

  Approved by: Name: _____ Title:_____

  Phone: _____Ext: ____ Email address:_____

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