**DSRIP Statewide Investment Student Loan Repayment Program**

**Licensed Certified Social Workers | Licensed Independent Clinical Social Workers**

**Licensed Mental Health Counselors | Licensed Marriage and Family Therapists**

**Licensed Alcohol and Drug Counselors I**

* LCSWs, LICSWs, LMHCs, LMFTs, and LADC1s employed at CMHCs (inclusive of community-based mental health centers, substance use programs, and psychiatric day treatment programs), Behavioral Health (BH) Community Partners (CPs) or their Consortium Entities or Affiliated Partners, CSAs, or organizations contracted with an ACO to provide In-Home Therapy (IHT) should apply to the **DSRIP Statewide Investments Behavioral Health Workforce Development Program.**
* LCSWs, LICSWs, LMHCs, LMFTs, and LADC1s employed at Community Health Centers (CHCs) or Long Term Services and Supports (LTSS) Community Partners should submit their application to the **DSRIP Statewide Investment Student Loan Repayment Program**.
* If all the slots in the **DSRIP Statewide Investment Behavioral Health Workforce Development Program** are filled, remaining applications may be moved by EOHHS to the **DSRIP Statewide Investment Student Loan Repayment Program** for further consideration without any additional work by the provider. See DSRIP Statewide Investments Behavioral Health Programs Flow Chart for more detail.

**APPLICATION REQUIREMENTS GUIDANCE AND CHECKLISTS**

***Applicant Checklist*** *(Recommender Information follows)*

This Checklist reflects core application requirements. We reserve the right to ask for additional information or clarification. You must initial each item on this **Checklist,** and sign and date the Checklist below. Your signature indicates that you understand all items required by the application. **Return this Checklist with your application. Keep a copy of the application package for your records. No application materials will be returned to applicants. Please see dates for Committee review and decision making times in Information for Applicants document.**

\_\_\_\_1. Completed **Application Form** for Student Loan Repayment Program.

\_\_\_\_2. **Two Letters of Recommendation** for Student Loan Repayment Program.

\_\_\_\_3. Completed **Loan Information and Verification Form** for each loan for which you are seeking repayment assistance.

\_\_\_\_4. Copies of your **original loan application, promissory notes, disclosure statements, and statements from current holder indicating the borrower’s name, amount borrowed, date of original disbursement, and type of loans are required with a Loan Information and Verification Form completed for each loan.**

\_\_\_ 5. Copies of **current account statement** showing your loan balance for each loan submitted. The current account statement must be dated not more than 90 days before the postmark on the application.

\_\_\_ 6. **Payment Information Form** for each qualified loan.

\_\_\_ 7. Completed **Authorization to Release Information Form**

\_\_\_ 8. **Employer Application**.

\_\_\_\_9. Copy of your **degree**.

\_\_\_\_10. Copy of your **permanent license** **to practice in Massachusetts** with an expiration date if you have your license. Copies of all current state licenses.

\_\_\_\_11. Provide copies of “Responses to Information Disclosure Request” by requesting a Self-Query through the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Band (HIPDB) ([www.npdb-hipdb.hrsa.gov](http://www.npdb-hipdb.hrsa.gov)). *Please note that the response to the Self-Query may take up to a month to receive; please plan accordingly. We will accept an electronic copy of the Self-Query in replace of the original as the applicant waits for original to arrive. The Self-Query should be submitted in its original sealed envelope. The Self-Query must be dated within 3 months of the application due date.*

\_\_\_12. **Proof of U.S. citizenship or status as a permanent/legal resident.**  A copy of U.S. passport, birth certificate, or residency certificate.

\_\_\_13. Copy of your **specialty board certification or residency completion certification**.

\_\_\_14. Copy of your **curriculum vitae/resume**.

\_\_\_15. **Initialed, signed and dated Checklist**.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (print) Signature Date

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*This application is designed to be completed electronically as a Word file. Please use the tab or place your cursor over the gray boxes to navigate the form. Field size will expand to accommodate entered text. Once completed, print, sign and submit along with other application materials to the fax number or mailing address at the end of this document.*

APPLICATION FORM

### Section A: Biographical Information

**Name**

 *Last First Middle*

Please list all credentials in your title:

Home Address

 *Street*

 *City State Zip Code*

Home Phone (   )    -

Work (   )    -

Cell (   )    -

Fax (   )    -

Professional E-mail

Secondary E-mail

Date of Birth

Gender (check) [ ] Male / [ ] Female/ [ ]  Transgender Male/ [ ]  Other

Languages Spoken

How did you hear about this program?

**Program(s) Attended**

Year of Graduation

# If applicable, Other Graduate Program

# Year Licensure Received (LCSW, LICSW, LMHC, LMFT, LADC1)

***Complete if negotiating or committed to employment at eligible organization/entity:***

Type of Organization/entity:

[ ] Community Health Center [ ] Community Mental Health Center (inclusive of community-based mental health centers, substance use programs, and psychiatric day treatment programs) [ ] Emergency Service Program [ ] Community Service Agency

[ ]  Community Partner or their Consortium Entity or Affiliated Partner [ ] Organization Contracted with an ACO to Provide IHT

Organization/Entity Information:

Organization/Entity Name:

Organization/Entity Address for expected employment:

Organization/Entity Primary Phone Number:

Start Date of Employment at organization/entity        *or*

Committed Employment Start Date

[ ]  Full-time  [ ]  Part-time

|  |  |
| --- | --- |
| **Clinical Sessions (minimum of 20 hours for PT or 24 hours for FT)** | **Case Management Time (approx. 1 hour/clinical session)** |
| # of Sessions | Total Hours | Hours |
|       |       |       |
|  |  |  |
| **Total hours at CHC, CMHC, ESP, CSA, CP or their Affiliated Partner or Consortium Entity** (**clinical, teaching, research, admin, etc)** |  |
|       |  |

\*See the Behavioral Health Workforce Development Information for Applicants document for the definition of full-time and part-time and more information on case management/care coordination.

**Section B: Professional Activities and Community Service**

1. Provide a copy of your *curriculum vitae,* including information regarding your academic and clinical training, including, fellowship training, teaching appointments, and research experience as appropriate, as well as information regarding your employment history. Include any honors, identifying awards received during or since completing your academic and clinical training.
2. List and describe any volunteer work, community service, advocacy efforts and leadership activities in which you have been involved. Please describe those efforts focusing on underserved or special populations.

Essays

Each essay should not exceed a maximum 500 words (reviewers will not read beyond this limit)

1. Please share your vision of health and describe how you have demonstrated your commitment to this vision. Please share your interest in practicing at a community-based organization within Massachusetts.
2. Please describe the professional goals you have set for yourself to achieve over the next four years at your community-based organization. What resources and/or support will you need to accomplish your goals? Describe the opportunities and challenges that you perceive community health organizations face and how this will might impact your career in the future.
3. Please share your perspective on the shift from volume- to value-based payment and the integration of physical and behavioral health in the Massachusetts health care system. How does this align with your work in a community-based setting?
4. If you have not yet obtained your license, please describe your plans for obtaining your license within the next year.

Section C: Educational Indebtedness

What is the approximate total of your outstanding educational loans?      \* as of (date)

 *\*please deduct any amount in a Learning Contract from total outstanding education loan indebtedness*

Are any of your educational loans in a delinquent status? [ ] Yes [ ] No

If yes, describe below the financial circumstances resulting in the delinquency.

Copy of loan balance(s) from month previous to this application, attached [ ] Yes [ ] No

Please list your qualified educational loans below and **please indicate the order of which you would like the loans to be paid – loan disbursements can be applied to multiple accounts**. (Attach additional page(s) if necessary.)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Loan Holder/Servicer’s Name,Address, and Telephone Number | Loan Type | Account Number | Current Balance | Ranking for Disbursement |
|       |       |       |       |       |
|       |       |       |       |       |
|       |       |       |       |       |
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|       |       |       |       |       |

Please describe, on a separate page, any special circumstances or economic hardships that you would like us to consider in reviewing your application.

Are you currently participating in or applying for any of the following federal, state, private or employer- sponsored loan repayment programs? Please check all that apply on left and answer questions on right, if applicable.

1. [ ]  National Health Services Corps (NHSC) NHSC Expected Award Notice Date :

 *Period receiving funding:* From:       To:

1. [ ]  UMass Learning Contract Amount of debt in contract:
2. [ ]  Other :       Date of Discharge:

### Section D: Other Information

Provide two letters of recommendation. At least one letter must be from a supervisor who can independently evaluate your work and one letter from a person of your choice (i.e. colleague). Letters should address how you are suited to practice in a community-based organization working with underserved populations. List the names of these individuals and their professional relationship to you along with their phone numbers, postal and email addresses. Letters of recommendation can either be mailed directly to the Massachusetts League of Community Health Centers by the recommender, or included along with the applicant’s other materials.

**1.** Name:

 *Last First Middle Title*

Address:

 *Street City State Zip Code*

Telephone: (   )   -     Email Address

Relationship to applicant:

**2.** Name:

 *Last First Middle Title*

Address:

 *Street City State Zip Code*

Telephone: (   )   -     Email Address

Relationship to applicant:

***Recommender Guidance***

**Please provide this checklist to each person who will be writing one of your Reference Letters.**

**\*\*Please be sure to print all application materials on one-sided pages. Thank you.**

\_\_\_\_1. **Letters of Reference** from at least two individuals who are in a position to evaluate your current clinical skills.

 Guidance for letters of reference:

 In considering what to include in your letter of reference, recommenders are encouraged to include

 information about:

-the length of time acquainted with the provider

-provider’s experience serving underserved populations

-exceptional abilities in providing care

-areas of expertise of motivations for choosing community based care

-particular achievements in previous similar roles or at their organization so far

-anything else you deem important in painting a picture of the provider

for the Application Review Committee

Reference Letters can either be mailed directly to the Massachusetts League of Community Health Centers or emailed by submitting along with the Applicant’s other application materials. Please send letter(s) to:

**Massachusetts League of Community Health Centers**

**DSRIP Statewide Investments Student Loan Repayment Program**

**Alexis Murray, Director, Primary Care Workforce Initiatives**

**40 Court Street, 10th Floor**

**Boston, MA 02108 617-988-2253**

**Fax: (617) 426-0097**

**Provide affirmation of the eligibility criteria by initialing the following items:**

|  |  |
| --- | --- |
| ***Statement*** | ***Affirmation*** |
| I, the applicant, am a United States Citizen or a legal resident of the United States. |  |
| I have a current and non-restricted license or certificate to practice in the Commonwealth of Massachusetts or indicate date you will be eligible and applying. |  |
| I do not have an existing unsatisfied obligation to the National Health Service Corps, or to any other federal, state or local government or other entity for health professional service. |  |
| I agree to provide clinical services to any individual seeking care and will not discriminate on the basis of the patient’s ability to pay for care. |  |
| I do not have a judgment lien against my property for a debt to the U.S. government. |  |
| If awarded a loan through this program, I will work fulltime (or part-time if contracted for part-time) in an eligible organization for four years. |  |

Please provide any other information that you would like us to consider as we review your application. (Attach additional pages.)

**By signing below, I authorize the MLCHC to confirm my interest, qualifications and employment opportunity with interested community health centers, community mental health centers (inclusive of community-based mental health centers, substance use programs, and psychiatric day treatment programs), emergency service programs, Community Service Agencies, Community Partners or their Affiliated Partners or Consortium Entities or organization contracted with an ACO to provide IHT.**

By signing below, I certify that the information that I have submitted in this application is complete and correct to the best of my knowledge and belief.

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

Please fax complete application to the information below or mail hard copy to the mailing address below:

#### Massachusetts League of Community Health Centers

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