**profes MASSACHUSETTS LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS** 

**Sponsored by the Massachusetts Department of Public Health (MDPH) – Health Care Workforce Center**

**Managed by the Massachusetts League of Community Health Centers, Inc. (MLCHC)**

**Match Funded by the USDHHS Health Resources and Services Administration**

**Massachusetts Loan Repayment Program (MLRP)**

**2020 Application Form**

**Application Instructions: THIS APPLICATION MUST BE POSTMARKED June 3, 2020 TO THE MLCHC**

* This application form is divided into three sections:
  1. Health Professional Information – *to be completed by the health professional applying for loan repayment.*
  2. Employer Information – *to be completed by a representative from the employer organization.*
  3. Application Checklist and Attachments – *list of documents that need to be attached to this application form.*
* The application form must be completed electronically using the spaces provided. Handwritten application forms will be returned to the health professional and will not be reviewed or considered for loan repayment.
* Once sections I and II of the application have been completed, print the application form (single-sided) and provide signatures in all required spaces using BLUE ink.
* Gather all the required documents listed in section III and include them in the order listed at the back of the signed application form.
* Use the checklist on page 11 to ensure that your application is complete. Please check off all the items that are included in this application packet before you submit. Incomplete applications will be returned to the health professional without review or consideration for loan repayment.
* Application must be mailed via United State Postal Services **ONLY**. No other forms of mail will be accepted at this time. **Application must be postmarked no later than June 3, 2020.** Submit the completed and signed application form along with all required attachments to the address below. Be sure to keep a copy of the application for your records.

*Alexis Murray**Massachusetts League of Community Health Centers, Inc.  
40 Court Street 10th floor  
Boston, MA 02108-2212*

**Section I. Health Professional Information**

**First Name: Middle Initial: Last Name:**

**Home Address: City: State: Zip Code:**

**Preferred Phone #: Work Phone #: Preferred E-mail Address:**

**Gender:** Choose an item.

**Race/Ethnicity**

*Are you Hispanic/Latino/Spanish?* Yes  No  Decline to Answer

*What is your race? (You can specify more than one)*

American Indian/Alaska Native  White

Asian  Other

Black  Decline to Answer

Native Hawaiian or other Pacific Islander

**In addition to English, indicate language(s) you speak with sufficient fluency to provide health care services:**

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

**Profession:** Choose an item.

**Specialty: Board Certified?** Yes  No

**Other Professional Certification(s):**

**School Attended for Health Professional Training: Year of Graduation:**

**Name of Residency Training Program: Date of Completion:**

**How did you hear about the MLRP?**

MLCHC/MDPH Communication or website  Colleague

College/University Services  Presentation at College/University

Residency  Internet Search

Employer  Other Click here to enter text.

**Have you previously received award(s) from the MLRP?**   Yes  No

**Do you have a current commitment to another incentive program?**  Yes  No

*If you are currently participating in another LRP you are not eligible for the 2020 MLRP.*

*If yes, check off which program(s) below:*

MLRP

Mass League of Community Health Centers BOA, MDPH or EOHHS DSRIP funds

National Health Service Corps (any)

UMass Learning Contract

Kraft Family National Center for Leadership & Training in Community Health

Other Click here to enter text.

**Time Commitment Remaining** (in months)**:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**Practice Site Name:**

**Practice Site Address: City: State: Zip Code:**

**Employment Start Date: # hours scheduled to work per week:**

**Essay Questions**

*Please respond to all 5 essay questions below. Responses must be provided in the corresponding text boxes below. Written or typed responses attached to this application will not be accepted. Responses are limited to a maximum number of characters, which are noted in each question. Once the character limit is reached, you will not be able to add any additional characters.*

1. **Please describe the patient population that you personally provide care for. Your response should include the following:** 
   * **General demographic breakdown of your patient population.**
   * **Vulnerable/underserved populations that you regularly provide care for, including:**
     + Homeless, incarcerated/recently incarcerated, LGBTQ, refugees and immigrants (regardless of status) in greater numbers than typical primary care practice, patients with disabilities, patients with HIV/AIDS, seasonal/migrant/transient workers, underserved racial/ethnic groups, and other vulnerable/underserved populations.
   * **Description of the specific needs and barriers to care of your patient population.**
   * **Any significant health disparities that exist in your community of practice.**

(*Text limit = 1500 characters, approximately 250 words)*

1. **Please describe how your educational background and previous professional experience has prepared you to meet the health care needs of your patient population(s) described in essay 1 and any past success in meeting those needs. Please include a previous success in addressing barriers to care for your patient population and reducing health disparities in your community of practice if applicable.**

(*Text limit = 2000 characters, approximately 325 words)*

1. **Please describe your previous personal and professional experience with the following:**
   * **Living and working in rural and/or underserved communities, including any previous experience in your current community of practice or similar community.**
   * **Working in under-resourced practice settings, including your current practice setting.**

(*Text limit = 1500 characters, approximately 250 words)*

1. **Based upon your experiences described in essay 3, what are some of the general challenges that come with:**
   * **Practicing in rural/underserved communities?**

* **Working in under-resourced practice settings?**

**Please describe some strategies you have employed to address/overcome these challenges.**

(*Text limit =1500 characters, approximately 250 words)*

1. **Please describe your long-term career goals, including any plans to continue working in your community of practice or other rural/underserved communities in the future.**

(*Text limit =1000 characters, approximately 160 words)*

**Affirm your eligibility by reviewing and initialing next to the following items:**

|  |  |
| --- | --- |
| **Statement** | **Affirmation**  (initials) |
| I, the health professional, am a United States citizen { } or national (naturalized citizen)[ ] |  |
| I have a current and non-restricted license to practice in the Commonwealth of  Massachusetts, appropriate for my MLRP application |  |
| I agree to provide primary care services as defined in the program guide to any individual seeking care and will not discriminate on the basis of the patient’s ability to pay for such care or on the basis that payment for such care will be made pursuant to public payer programs such as: Medicaid/MassHealth, Medicare, the State Children’s Health Insurance Program, Commonwealth Care Programs, the Health Care Safety Net or through a sliding fee scale. (refer to Payer Mix section) |  |
| I do not have a judgment lien against my property for a debt to the United States. |  |
| I have not defaulted on any federal payment obligations. This includes those obligations where the creditor now considers me to be in good standing; or any state obligations such as tax or support payments |  |
| I have not breached a prior service obligation to the Federal/State/local government or other entity, this includes any obligation that has subsequently been satisfied |  |
| I have not had any Federal debt written off as uncollectible (pursuant to 31 U.S.C. 3711(a) (3) or had any Federal service or payment obligation waived |  |

**Health Professional’s Qualifying Loan Statement**

**Health Professional Name:**

Attach a copy of your current and complete student loan statement(s)

* Loan statement should be from the month previous to, or month of, this application
* Must include your relevant full name and address
* HIGHLIGHT each outstanding loan on the loan statement(s)
* HIGHLIGHT payment address and methods for loans
* Below list each student loan carrier and the current outstanding loan amount
* Please list loans in preference order for payment if awarded LRP funding

|  |  |
| --- | --- |
| **Student Loan Carrier** | **Outstanding Loan Amount ($)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total Outstanding Loan Amount**  *(this field will update when you save and close the document)***:** | $ 0.00 |
| **Your Current Gross Annual Salary:** | Click here to enter text. |

*If you need more lines spaces, please attach a separate typed document that lists ALL of your student loan carriers and corresponding outstanding loan amounts and attach required statements with HIGHLIGHTS.*

*MLRP award amount will not exceed your total outstanding student loan amount.*

**Your signature and this application indicate that you have reviewed and understand the MLRP commitment as described in the MLRP guide and this application.**

**DECLARATION**

**This Declaration form must be signed by the Health Professional below in BLUE INK.**

All of the information on this application is truthful and accurate. I understand that knowingly submitting false information will void this application and may be considered a breach of my Massachusetts Loan Repayment Program (MLRP) for Health Professionals contract. If awarded MLRP funding I agree to sign a contract with the MLRP to provide two years of full-time service or equivalent in part- time service at an eligible Employer Healthcare Organization according to the specifications in the MLRP Guide by June 30, 2020. The two years of Service Commitment will start June 30, 2020 through June 30, 2022.

By signing this application (in BLUE INK), I agree to all of the conditions stipulated in the MLRP Guide.

Health Professional Signature: Date:

Print Full Name:

**Section II. Employer Information**

*This section is to be completed by a representative of the health professional’s employer organization.*

**Employer Healthcare Organization:**

**Employer Contact Name: Title:**

**Employer Phone #: Medicaid Billing #:**

**Employer Address: City: State: Zip Code:**

**Employer Contact E-mail:**

**Employer and Practice Site (if different from employer) are non-profit entities:** Yes No

***Select drop down list for Site Type:***

**Practice Site Type**  Choose an item. If other, please specify: Click here to enter text.

**Federal Shortage Designation - The HPSA for the employer and site where the MLRP applicant will work must match the MLRP applicant’s health professional discipline. Pharmacists and substance use disorder (SUD) clinicians can work at a site located in either a Primary Care Health Professional Area (HPSA) OR a Mental Health Professional Shortage Area.**

|  |  |
| --- | --- |
| ***If applicable, provide the following information:*** | *Shortage designation information can be found at:* [*https://bhw.hrsa.gov/shortage-designation/*](https://bhw.hrsa.gov/shortage-designation/) |
| **Type of Federal Shortage Designation:** Choose an item. |
| **Federal HPSA#:** | **HPSA Score:** |

**Full Name of Health Professional Applying for Loan Repayment:**

**# Hours per Week of Direct Outpatient Care: # Hours per Week of Non-Patient Care Duties:**

**Employer Letter of Support**

Please provide a letter of support on behalf of the health professional. *Please limit the letter to two typed page or less.*

The letter of support should include:

* The value that the health professional brings to the practice site.
* A description of needs at the practice site that the health professional is helping to fill (e.g. treating rural and/or unserved/underserved populations, bringing cultural/linguistic expertise, providing unique services and skills)
* An overview of the retention plan for the health professional applying for loan repayment.
* Current recruitment and retention strategies for providers at the practice site, including the importance of programs like MLRP in recruitment/retention.

**Provide assurance of employer eligibility by initialing the following items as appropriate in column to the right:**

|  |  |
| --- | --- |
| **Statement** | **Affirmation**  (initials) |
| Health professional will provide services in a public or a non-profit organization that holds any required MDPH licenses. For-profit employers or practice sites are not eligible. |  |
| The employer healthcare organization (and billing entity if different) is certified as a provider by MassHealth and complies with the regulations governing MassHealth; accepts Medicare; and accepts patients enrolled in Commonwealth Care programs and the Health Safety Net. |  |
| The employer healthcare organization (and billing entity if different) is certified as a provider by MassHealth and has a rate established by the Center for Health Information and Analysis (CHIA), and is in compliance (good standing) with MassHealth regulations and certifications. |  |
| Health professional’s employer healthcare organization (and billing entity if different) must charge for their professional services at the usual and customary prevailing rates in the area in which such services are provided, except if a person is unable to pay the charge, such person shall be charged at a reduced rate using a schedule of fees for those at various income levels and will display a notice of availability of discounted fees for the uninsured (i.e. sliding fee scale) or not charged any fee. |  |
| The employer healthcare organization provides documentation of fee schedule or sliding fee scale and policy with this application. |  |
| The employer health care organization agrees to provide primary care services through the eligible health professionals as defined in the MLRP guide, to any individual seeking care. MLRP awardees and employer (and site, if different) must agree not to discriminate on the basis of the patient’s ability to pay for such care or on the basis that payment for such care will be made pursuant to public payer programs such as: Medicaid/MassHealth, Medicare, the State Children’s Health Insurance Program, the Commonwealth Care Programs, the Health Care Safety Net or through a sliding fee scale. (refer to payer mix section). |  |
| If employment site is different than the hiring employer organization, a support letter from the employment site is attached (refer to MLRP program guide, section on Obligations of the Employer Healthcare Organization). |  |

The health professional’s employer healthcare organization certifies that it meets the eligibility requirements and has provided truthful information regarding the employment of the health professional and understands the need for compliance with all specifications set forth by the Massachusetts Loan Repayment Program (MLRP) for Health Professionals Program Guide. The Employer Healthcare Organization certifies that loan repayment funds will not be used to supplant an MLRP provider's expected wages or benefits as compared to other similarly qualified and situated employees.

Indicate the health professional’s current annual gross salary: $Click here to enter text.

As a representative of Click here to enter text., I recommend Click here to enter text. for the MLRP.

**If your organization is supporting more than one health professional application during this calendar year, please indicate the priority of this application relevant to other applications submitted by the organization:**

**1st choice  2nd choice 3rd choice**

SIGNATURE OF AUTHORIZED REPRESENTATIVE in BLUE INK:

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

**Full Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Payer Mix Information**

*Provide the following patient payer mix percentage. This payer mix information should come from agency billing or financial system data or for FQHCs from the annual UDS Report. Do not complete if correctional or detention facility.*

**Payer Mix at Practice Site**

|  |  |
| --- | --- |
| **Insurance Coverage** | **% of Patient Population** |
| MassHealth (include dual eligible) |  |
| Commonwealth Care |  |
| Commonwealth Choice |  |
| Health Safety Net |  |
| Children’s Medical Security Plan |  |
| Medicare only |  |
| Self-Pay |  |
| Other/Private insurance |  |

**Please note where the above payer mix data was derived from, and the time period it represents (e.g. calendar year):**

**Signature of Authorized Representative:**

**Full Name: Title:**

**Section III. Application Checklist and Attachments**

**Below is a checklist of documents and attachments that must accompany the application. Attach each item in the order that it is listed below to the back of the completed and signed application form.**

Completed application form, including Health Professional Information section completed and signed by health professional AND Employer Information section completed and signed by appropriate employer representative

Copy of current qualifying loan statement(s). Must include name and address of the health professional

Copy of recent health professional’s pay stub

Current resume or curriculum vitae of health professional

Copy of the health professional’s current, un-restricted, Massachusetts professional license

Proof of U.S. citizenship (copy of passport or birth certificate) or status as a national (naturalized citizen).

Letter of Support from the employer (as instructed in Employer Section on page 8 of the application)

If practice site is different from hiring employer organization, support letter is also required from the practice site.

\*A copy of non-profit or not-for-profit documentation for the health care organization/employer or practice site

\*A copy of your practice site’s sliding fee scale and policy. Your site’s sliding fee scale should reflect current federal poverty guidelines. Federal guidelines link: <http://aspe.hhs.gov/poverty/>

***\**** *Not required for FQHC and correctional facility applicants*

The awarded Loan Repayment Funds will be paid directly to the awardee’s education loan carriers in the amount awarded. Please complete the Qualifying Loan List under Section I and the current Loan Statements.