**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)**

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

**Massachusetts Loan Repayment Program (MLRP)**

**2024 Application Form**

**THIS APPLICATION MUST BE POSTMARKED NO LATER THAN JANUARY 19th, 2024, TO THE MLCHC.**

**Application Instructions:**

* This application form is divided into four sections:
  1. **Health Professional Information – *to be completed by the health professional applying for loan repayment.***
  2. **Health Professional Student Loan Information – to be completed by the health professional and accompanied with supporting documentation.**
  3. **Employer Information – *to be completed by a representative from the employer organization.***
  4. **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 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.
* Gather all the required documents listed in section IV and include them in the order listed at the back of the signed application form.
* Use the checklist on page 13 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 not be reviewed 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 January 19th, 2024.** 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.

Massachusetts League of Community Health Centers, Inc.

Attention: MLRP Workforce Program  
40 Court Street, 10th Floor

Boston, MA 02108

**Section I. HEALTH PROFESSIONAL INFORMATION**

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

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

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

**Gender:** Choose an item. **Pronouns:** Click here to enter text. **Date of Birth:**

**Race/Ethnicity**

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

What is your Ethnicity? Choose an item.

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

American Indian/Alaska Native  White

Asian  Decline to Answer

Black  Other (*Please specify*): Click here to enter text.

Native Hawaiian, or other Pacific Islander

Have you ever served on active duty in the U.S. Armed Forces, Military Reserves or National Guard?

Yes  No  Decline to Answer

If yes, are you currently on active duty?

Yes  No  Decline to Answer

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

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Do you identify as being from a rural residential background?Yes  No  Decline to Answer

Do you identify as being from a disadvantaged background?Yes  No  Decline to Answer

**Profession:** Choose an item.

**Specialty: Board Certified?** Yes  No

**License Number: NPI Number:**

**Other Professional Certification(s) & Certification #:**

**Medicated Assistance Treatment (MAT) Certified?** Yes  No

**Do you hold a Data 2000 Waiver?** Yes  No

**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 Communication or website  Colleague

MPDH Communication or Website  Presentation at College/University

USDHHS/HRSA Communication or Website  Internet Search

College/University Services  Residency

Employer  Other Click here to enter text.

**Have you applied to any other loan repayment programs (including the National Health Service Corps)?**

Yes (*Please specify*): Click here to enter text.  No

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

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

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

MLRP

MA Repay

DSRIP Student Loan Repayment Program/EOHHS DSRIP Funds

National Health Service Corps (any)

UMass Learning Contract

Other Click here to enter text.

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

*If you are currently participating in another LRP you are not eligible for the 2024 MLRP.*

***The following section is required and must be filled out for the application to be considered complete. “N/A” will not be an accepted answer for this section.***

**Practice Site Name:**

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

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

**If you have more than one practice site, please provide the information requested above in the space below:**

**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 how the patient population you personally provide care for has increased access to primary care and/or behavioral health services in the community where you work. Be specific about the patient population you serve including the following:**
   * General demographic breakdown of your patient population
   * Vulnerable/underserved populations that you regularly care for.
   * Description of the specific needs and barriers to care for 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 background, including your lived experience, educational, and professional experience has prepared you to meet the health care needs of your patient population(s) described in essay one. Please include any 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. **What does health equity look like to you? How has your background and experiences living and working in a rural and/or underserved community influenced this vision and/or contributed to your decision to practice at a primary care, oral health, or behavioral health organization within Massachusetts?**

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

1. **Please describe the professional goals you have set for yourself to achieve over the next two years at your organization. What resources and/or support will you need to accomplish your goals? Describe the opportunities and challenges that you perceive community-based primary care, oral health, or behavioral health organizations face and how they might impact your career in the future.**

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

1. **If you are a bachelors-level addiction clinician who is not yet licensed, please provide your specific plans for obtaining professional licensure.**

(*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 based on 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. |  |

**Section II. HEALTH PROFESSIONAL STUDENT LOAN INFORMATION**

**Health Professional Name:**

**Health Professional Date of Birth (DOB):**

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

* Loan statement should be from the month before, 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 servicer and the current outstanding loan amount.
* Please list loans in preference order for payment if awarded LRP funding.

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| --- | --- |
| **Student Loan Servicer** | **Outstanding Loan Amount ($)** |
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| **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 your student loan servicers 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**

**The Health Professional applying to the MLRP must sign this Declaration form below.**

All 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, 2026. The two years of Service Commitment will start June 30, 2024, through June 30, 2026.

By signing this application, I agree to all conditions stipulated in the MLRP Guide.

**Health Professional Signature**: **Date**:

**Print Full Name**:

**Section III. EMPLOYER INFORMATION**

*A representative of the health professional’s employer organization must complete this section.*

**Employer Healthcare Organization:**

**Direct Supervisor Name: Title:**

**Direct Supervisor Phone #: Medicaid Billing #:**

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

**Direct Supervisor 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:

**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 Shortage Area (HPSA) OR a Mental Health Professional Shortage Area.**

|  |  |
| --- | --- |
| ***If applicable, provide the following information:*** | *Shortage designation information can be found at:* [*https://data.hrsa.gov/tools/shortage-area*](https://data.hrsa.gov/tools/shortage-area) |
| **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 pages 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 the 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 healthcare organization agrees to provide primary care and/or behavioral health services through 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 employer will be responsible for signing Service/Engagement Verification Forms and Service Commitment Verifications certifying that the employee remains employed at their location and upon completion of the program, the employer is encouraged to complete program surveys. |  |

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:** $

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:

**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 |  |
|  | **Insurance Coverage Source Information** |
| Payer Mix Source: |  |
| Time Period Represented (e.g., calendar year): |  |

**Signature of Authorized Representative:**

**Full Name: Title:**

**Section IV. 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 (I) Health Professional Information section completed and signed by health professional, (II) Health Professional Student Loan Information section, AND the (III) Employer Information section completed and signed by appropriate employer representative.

Copy of current qualifying loan statement(s). Must include the 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 the Employer Section on page 10 of the application) If the 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 servicer in the amount awarded. Please complete the Qualifying Loan List under Section II and the current Loan Statements.