# Well-Ahead Louisiana Primary Care Office

**Louisiana Rural Physician Loan Repayment Program Application**

## Section A: Personal Data

Applicant Name:

Social Security Number or TIN:

Home Address:

Mailing Address (if different from Home):

Main Phone Number:

Alternate Phone Number:

Email:

Date of Birth:

Are you a U.S. citizen/national?
☐ Yes ☐ No

City and State of Birth:

**Questions 1-3 are required for federal/state reporting purposes.**

1. Race/Ethnicity (check one): ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Hispanic
2. Did you participate in an Area Health Education Center health career program? ☐ Yes ☐ No
3. Did you grow up in Louisiana? ☐ Yes ☐ No
   If yes, in a rural area (under 25,000 population)? ☐ Yes ☐ No

## Section B: Health Profession Choice and Education

1. Health Profession (choose one):
   - ☐ M.D. - Family Medicine
   - ☐ M.D. - General Internal Medicine
   - ☐ M.D. - IM (with sub-specialty training)
   - ☐ M.D. - OB/GYN
   - ☐ M.D. - Pediatrician
   - ☐ M.D. - Psychiatrist
   - ☐ Primary Care Physician Assistant
   - ☐ General Dentistry (DDS or DMD)
   - ☐ Pediatric Dentist
   - ☐ Licensed Dental Hygienist
   - ☐ P. C. Certified Nurse Practitioner
   - ☐ Certified Nurse Midwife
   - ☐ Health Service Psychologist
   - ☐ Licensed Clinical/Counseling Psychologist
   - ☐ Psychiatric Nurse Specialist
   - ☐ Licensed Clinical Social Worker
   - ☐ Licensed Marriage and Family Therapist
   - ☐ Licensed Professional Counselor
   - ☐ Alcohol and Substance Abuse Counselor

2. Education Information
   Undergraduate Degree:
   Graduate Date:
   Undergraduate School Name:
   Undergraduate School Address (City, ST, Zip):

   Medical/Dental School Specialty:
   Graduate Date:
   Medical/Dental School Name:
   Medical/Dental School Address (City, ST, Zip):

   Residency Program Specialty Type:
   Start and End Dates:
   Residency Program Address (City, ST, Zip):

   Fellowship Program Specialty Type:
   Start and End Dates:
   Fellowship Program Address (City, ST, Zip):

3. Are you (check if applicable): Board Certified? ☐ Board Eligible? ☐

4. Louisiana License Number:
   Date Issued:

5. National Provider Identifier (NPI) Number:

6. Medicare Identification Number:

7. Medicaid Identification Number:

## Section C: Educational Debt

List below, in priority order, the first four educational loans received during undergraduate and graduate professional study. **Educational loans considered part of this loan repayment plan may be consolidated—but not with non-educational loans.** Current loan balance statements must be submitted with this application. Include additional loans on a separate sheet of paper.

Loan 1: Loan Program Name and Address

Account Number:

Current Principle Balance:

Academic period covered by loan:

Loan 2: Loan Program Name and Address

Account Number:

Current Principle Balance:

Academic period covered by loan:

Loan 3: Loan Program Name and Address

Account Number:

Current Principle Balance:

Academic period covered by loan:

1. Applicant agrees to provide outpatient primary care for three (3) years—check to verify ☐ Yes
2. Are any of the loans listed above or any other part of your medical education being repaid through another loan repayment program? ☐ No ☐ Yes
3. If yes, please provide the name of the loan repayment program:
4. Are any of the loans listed above or any part of your medical education being repaid through any type of service obligation? ☐ No ☐ Yes
   If yes, please provide the name and address of entity to which the obligation is owed:
5. Has this obligation been satisfied? ○ No ○ Yes (if yes, attach documentation)
6. Date obligation was repaid:
7. Are you now or have you ever been declared in default on any educational loans? ☐ No ☐ Yes
8. If yes, please explain:
9. Are you now or have you ever been declared in default/breach of any federal contract/agreement or healthcare service agreement/obligation? ☐ No ☐ Yes
10. If yes, please explain:

11. Are you responsible for making Child Support payments? ○ Yes ○ No Are you current with these payments? ○ Yes ○ No
    If no, please explain:

12. Is there an Income Assignment Order in place for Child Support Payments? ○ Yes ○ No

13. The Bureau of Chronic Disease Prevention and Healthcare Access checks defaulted student loan status by providing LOSFA with each applicant's name and social security number. The information is provided in a password protected spreadsheet. Do you give the Bureau permission to share this information with LOSFA? ○ Yes ○ No

14. Do you work with opioid addiction treatment? ○ Yes ○ No

## Section D: Other Information about the Louisiana Rural Physician Loan Repayment Program

1. Any individual who owes an obligation of professional healthcare service to the federal government, any other state government agency or any other entity under an agreement with said entity is ineligible to receive payment under this program until obligation has been completely satisfied. This obligation must be satisfied prior to beginning service under this program.

2. The following forms, with original signatures, must be included with this application: *Agreement for All Participating LRPLRP Sites Form*; *Attestation of No Other Obligation Form* (complete all sections and have form notarized); *Certification Regarding Environmental Tobacco Smoke Form*; *Release from Liability Form*; *Consent for Release of Information and Waiver of Confidentiality Form*; and *Site Information Form*. These can be found on pages 26-34 of this guidance.

3. Louisiana Rural Physician Loan Repayment Program funds are not taxable by the federal government. However, these funds are **TAXABLE** by the State of Louisiana. You will receive a Form 1099 from the LA Louisiana Department of Health each year you receive funds through the program. You are allowed to withhold 6% of monthly payments to pay state income taxes. Whatever is not paid on taxes will be applied to your educational loan.

4. Every April and October of each LRPLRP contract year, you will be responsible to verify the balance of your loans by sending the Louisiana Rural Physician Loan Repayment Program Manager a copy of your current educational loan principle balance. You are required to submit the Site Information Form at this time as well.

5. Each quarter that you are eligible for assistance through the Louisiana Rural Physician Loan Repayment Program you must submit a quarterly report of your practice activities. This report acts as your invoice for that quarter's loan repayment assistance. **These reports are due by the 15th of the month following the reporting quarter. If these reports are not received by the 15th of the following month, the state reserves the right not to honor that quarter's payment.** Allow 3 weeks from the 15th of the month following the end of the quarter for your payment to be issued.

6. Application for participation in the Louisiana LRPLRP does not guarantee that funds will be available. If the applicants' total needs are greater than the amount of LRPLRP funds available, the LRPLRP Priorities as described in the LRPLRP Policy will be used to determine which applicants will receive LRPLRP awards.

**CERTIFICATION:** In signing and returning this application to the Louisiana LA Louisiana Department of Health (LDH) Bureau of Chronic Disease Prevention and Healthcare Access, I hereby certify that I have read and understand the information contained in this application and the entire Louisiana Rural Physician Loan Repayment (LRPLRP) policy. I also certify that as indicated by my signature below, I am in agreement with the terms and conditions set forth in this application and in the LRPLRP policy, including the terms of waivers, suspensions, cancellations, defaults, and repayments. I also certify that I will review all the terms of the LRPLRP contract if I am awarded funding, including the dates of the contract period. I am also indicating that I am in agreement with completing my service obligation to meet the conditions of the LRPLRP contract, as outlined in the LRPLRP policy. These conditions will be outlined in the contract and its Attachments 1-7 also. I am affirming that all statements made by me during this application process are complete and accurate to the best of my knowledge. I am indicating by my signature my agreement to participate in this program by entering into an agreement in the form of a contract with Attachments 1-7 with Louisiana LDH for repayment of my educational loans, which are listed in Section C of this application, in exchange for my services.

These services will be provided as outlined in the LRPLRP contract and in Attachment 1 of the contract, if I am approved for funding and my LRPLRP contract is approved. I understand that returning this application does not mean automatic approval. I am aware that if the applicants' needs for this application period exceed the amount of funding available, the applications will be funded according to the priority facility list found in the LRPLRP policy, as well as the priority placed by the review committee. I also understand that if I am awarded funding, a contract will be mailed to me for my review/signature. I understand that the contract will not be in effect until it is returned to LDH and approved by the Division of Administration, Office of State Procurement. I also understand that once final approval has been granted, all terms and conditions of the contract will be in full effect and binding for me and the State of Louisiana, including the terms of default, as outlined in the LRPLRP Policy and in Attachments 3 and 4 of the LRPLRP contract.

_____ _____

Applicant Signature Date