Well-Ahead Louisiana Primary Care Office

State Loan Repayment Program Application

# Section A: Personal Data

Applicant Name: Social Security Number or TIN:

Click or tap here to enter text. Click or tap here to enter text.

Home Address: Mailing Address (if different from Home):

Click or tap here to enter text. Click or tap here to enter text.

Click or tap here to enter text. Click or tap here to enter text.

Main Phone Number: Alternate Phone Number:

Click or tap here to enter text. Click or tap here to enter text.

Email: Date of Birth:

Click or tap here to enter text. Click or tap here to enter text.

Are you a U.S. citizen/national?

[ ]  Yes [ ]  No

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

1. Race/Ethnicity (check one): [ ]  White [ ]  Black [ ]  Native American [ ]  Asian [ ]  Hispanic
2. Gender: [ ]  Male [ ]  Female [ ]  Other
3. Did you participate in an Area Health Education Center health career program? [ ]  Yes [ ]  No
4. Did you participate in the Rural Health Scholars Program?
5. Are you a veteran?
6. Did you grow up in Louisiana? [ ]  Yes [ ]  No
If yes, in a rural area (under 25K population) ? [ ]  Yes [ ]  No
If no, do you come from a disadvantaged background? [ ]  Yes [ ]  No
7. DATA 200 Waiver/MAT Service? [ ]  Yes [ ]  No
Substance Use Disorder License/Certificate? [ ]  Yes [ ]  No

# Section B: Health Profession Choice and Education

1. Health Profession (choose one):
[ ]  M.D. - Family Medicine [ ]  P. C. Certified Nurse Practitioner
[ ]  M.D. - General Internal Medicine [ ]  Certified Nurse Midwife
[ ]  M.D. - IM (with sub-specialty training) [ ]  Health Service Psychologist
[ ]  M.D. - OB/GYN [ ]  Licensed Clinical/Counseling Psychologist
[ ]  M.D. - Pediatrician [ ]  Psychiatric Nurse Specialist
[ ]  M.D. - Psychiatrist [ ]  Licensed Clinical Social Worker
[ ]  Primary Care Physician Assistant [ ]  Licensed Marriage and Family Therapist
[ ]  General Dentistry (DDS or DMD) [ ]  Licensed Professional Counselor
[ ]  Pediatric Dentist [ ]  Alcohol and Substance Abuse Counselor
[ ]  Registered Dental Hygienist
2. Education Information
Undergraduate Degree: Click or tap here to enter text.
Graduate Date: Click or tap here to enter text.
Undergraduate School Name: Click or tap here to enter text.
Undergraduate School Address (City, ST, Zip): Click or tap here to enter text.

Medical/Dental School Specialty: Click or tap here to enter text.
Graduate Date: Click or tap here to enter text.
Medical/Dental School Name: Click or tap here to enter text.
Medical/Dental School Address (City, ST, Zip): Click or tap here to enter text.

Residency Program Specialty Type: Click or tap here to enter text.
Start and End Dates: Click or tap here to enter text.
Residency Program Address (City, ST, Zip): Click or tap here to enter text.

Fellowship Program Specialty Type: Click or tap here to enter text.
Start and End Dates: Click or tap here to enter text.
Fellowship Program Address (City, ST, Zip): Click or tap here to enter text.
3. Are you (check if applicable): Board Certified? [ ]  Board Eligible? [ ]
4. Louisiana License Number: Click or tap here to enter text.
Date Issued: Click or tap here to enter text.
5. National Provider Identifier (NPI) Number: Click or tap here to enter text.
6. Medicare Identification Number: Click or tap here to enter text.
7. Medicaid Identification Number: Click or tap here to enter text.

# 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 Account Number:

Name and Address Click or tap here to enter text.

Click or tap here to enter text.

 Current Principle Balance:

 Click or tap here to enter text.

 Academic period covered by loan:

 Click or tap here to enter text.

Loan 2: Loan Program Account Number:

Name and Address Click or tap here to enter text.

Click or tap here to enter text.

 Current Principle Balance:

 Click or tap here to enter text.

 Academic period covered by loan:

 Click or tap here to enter text.

Loan 3: Loan Program Account Number:

Name and Address Click or tap here to enter text.

Click or tap here to enter text.

 Current Principle Balance:

 Click or tap here to enter text.

 Academic period covered by loan:

 Click or tap here to enter text.

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:

Click or tap here to enter text.

1. 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:
Click or tap here to enter text.

1. Has this obligation been satisfied? [ ]  No [ ]  Yes (if yes, attach documentation)
2. Date obligation was repaid: Click or tap here to enter text.
3. Are you now or have you ever been declared in default on any educational loans? [ ]  No [ ]  Yes
4. If yes, please explain: Click or tap here to enter text.
5. Are you now or have you ever been declared in default/breach of any federal contract/agreement or health care service agreement/obligation? [ ]  No [ ]  Yes
6. If yes, please explain: Click or tap here to enter text.
7. Are you responsible for making Child Support payments? [ ]  Yes [ ]  No
Are you current with these payments? [ ]  Yes [ ]  No
If no, please explain: Click or tap here to enter text.
8. Is there an Income Assignment Order in place for Child Support Payments? [ ]  Yes [ ]  No
9. 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
10. Do you work with opioid addiction treatment? [ ]  Yes [ ]  No

# Section D: Other Information About the Louisiana State Loan Repayment Program

1. Any individual who owes an obligation of professional health care 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 SLRP 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. State 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 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 SLRP contract year, you will be responsible to verify the balance of your loans by sending the State 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 State 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 SLRP does not guarantee that funds will be available. If the applicants’ total needs are greater than the amount of SLRP funds available, the SLRP Priorities as described in the SLRP Policy will be used to determine which applicants will receive SLRP awards.

CERTIFICATION: In signing and returning this application to the 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 State Loan Repayment (SLRP) 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 SLRP policy, including the terms of waivers, suspensions, cancellations, defaults, and repayments. I also certify that I will review all the terms of the SLRP 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 SLRP contract, as outlined in the SLRP 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 SLRP contract and in Attachment 1 of the contract, if I am approved for funding and my SLRP 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 SLRP 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 Louisiana SLRP Policy and in Attachments 3 and 4 of the SLRP contract.

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Applicant Signature Date