

**REQUIRED SUPPORTING DOCUMENTATION FOR NEW HAMPSHIRE STATE LOAN REPAYMENT
(SLRP) CONTINUATION APPLICATION**

- No continuation application will be considered unless all questionnaires are completed and supporting documents are submitted in a timely manner. Application are reviewed
 1. Copy of Current Resume.
 - For confidentially reasons please do not show home address & home phone, replace with employer address & work phone.
 - Must have current Employer and Practice Site(s) listed on updated resume
 - The resume is an important part of the contract, these request are required.
 2. Copy of Current New Hampshire Medical License or Certification for eligibility.
 - 3 If you are reapplying for an extension loan repayment funds, on a separate sheet, please explain how past, loan repayment loan awards have contributed to reducing your educational debt and has helped you serve the underinsured population of New Hampshire. (*Important: This descriptive material is very important and very carefully considered by the Selection Committee.*)
 4. Copies of all outstanding medical and/or dental educational loan balances to determine eligibility.
 - Education loan balances not received will not be considered for the loan repayment program.
 5. A copy of the National Health Service Corp letter stating that you are not eligible for funding if you have applied for the federal loan repayment through the request of the Rural Health & Primary Care Section or on your own initiative.
 6. Attach completed Employer Information Sheet; it will be your responsibility to make sure this portion of the application is completed along with the required documents and submitted timely. The employer may provide the employer information sheet & the copy of the “discounted sliding-tee-schedule” directly to the Rural Health & Primary Care Workforce Coordinator.
- Important: It will be the responsibility of the applicant and/or the facility/community to seek out non-federal matching funds. The benefit of matched funding contracts means that the applicant will not have to compete against any other applicant if qualified for the program. The State encourages a match because it shows an investment in primary health care, mental health and oral health care by the employer and/or community. Even a partial match is helpful in stretching our state resources. The applicants without any match are scored and compete for state funding with a larger group of qualified applicants, if funding is available. Make sure your employer/HR office has the proper information in regards to your application request.
- Please return completed application to:

N.H. Division of Public Health Services
Rural Health & Primary Care Section
C/o David Roberts, Workforce Coordinator
29 Hazen Drive, 2E
Concord, NH 03301-6504

If you have any questions, please e-mail or call the Workforce Coordinator at: droberts@dhhs.state.nh.us
O: (603)-271-2276, Fax: (603) 271-4506

To learn more about the State Loan Repayment Program you may go to our web site at:
<http://www.dhhs.nh.gov/dphs/bchs/rhpc/repayment.htm>

NEW HAMPSHIRE STATE LOAN REPAYMENT PROGRAM

Contractor Continuation Application Questionnaire

- Contractor's Continuation Applications will need to be submitted prior to your initial contract ending date. Example, if your initial contract will be ending on June 30th your continuation application will need to be submitted and received between December 16th through March 15th for the extension contract term to begin on July 1st. Applicants are responsible for submitting complete applications. The continuation application if not received timely for a decision, will affect the contract term date and the continuation of funds being paid quarterly.
- **Contract Terms begin July 1st, October 1st, January 1st and April 1st each state fiscal year (July 1st thru June 30th).**
 - An applicant who wants to be considered for a continuation contract term to commence on July 1st shall submit a completed application so that it is received by the Rural Health & Primary Care Section between December 16th through March 15th.
 - An applicant who wants to be considered for a continuation contract term to commence on October 1st shall submit a completed application so the Rural Health & Primary Care Section between March 16th through June 15th
 - An applicant who wants to be considered for a continuation contract term to commence on January 1st shall submit a completed application so that it is received by the Rural Health & Primary Care Section between June 16th through September 15th.
 - An applicant who wants to be considered for a continuation contract t term to commence on April 1st shall submit a completed application so that it is received by the Rural Health & Primary Care Section between September 16th through December 15th.
- The option to extend the continuation contract is contingent upon satisfactory delivery of services, remaining loan obligation of the Contractor, available State funding, agreement of the parties and approval of the Governor and Council.

Please type or print application:

Name: _____		
Last	First	Middle
Mailing Address: _____		
City: _____	State: _____	Zip: _____
Home Phone: _____	Cell: _____	E-mail: _____
Work Phone: _____	Work Fax: _____	
Soc. Security # _____ - _____ - _____	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>	

- Please check your discipline and provide specialty:
Discipline: MD DO Gen. Surgeon Psychiatrists DDS DMD
 PA APRN RDH CNM CP PNS MHC CSW MFT LPC
- Specialty: _____
- Are you still New Hampshire Board Certified? YES NO Date Expires: _____

- Current State Loan Repayment Contract obligation Dates: From ___/___/_____ through ___/___/_____
- Renewal option under the original loan repayment contract was for your initial contract:
 12 months 24 months Other
- Amount of original N.H. State Loan Repayment: \$_____

- Are you currently working for a State Sponsored Dental Program for the NH Division of Public Health Services/Oral Health Program Yes No?

If yes, please provide the Dental Program sponsored by the State: _____

- Are you an OB/GYN Physician, Family Practice Physician, Certified Mid-Wife who practice obstetrics on a regular basis? Yes No
- Are you currently working for a State Sponsored Dental Program for the NH Division of Public Health Services/Oral Health Program Yes No?
- In your discipline as primary care, mental health or oral health are you considered a:
 Full-Time Employee Part-Time Employee

Total Direct Patient hours per week: _____Hrs. Total Administrative hours per wk: _____Hrs.

- Has this changed from the initial contract commitment with the State Loan Repayment? YES NO
- If yes, Explain: _____

- How many maximum hours do you work in a week: _____ Hrs.
- Of your maximum hours per week, how many hours are administrative duties? _____Hrs.
- Maximum hours that you work to provide clinical services in an alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved service site(s). _____ Hrs.
- Maximum hours that you work in a week providing practice administrative duties: _____Hrs.
- How many days per week do you work: _____ Hrs.
- How many hours do you work in a day during a regular week: _____Hrs.
- Time spent "on call" during a regular week: _____Hrs. N/A
- Estimated hours directly serving patients during on call periods in a week: _____Hrs. N/A
- Hours spent on teaching or research during a regular work week: _____ Hrs. N/A
- The primary service site is located in a federal designed shortage area: HPSA MHPSA DHPSA MUA MUP EMUP Non-designated:

Click below to find out if your service site(s) is in a federal designated shortage area.

<http://nhsc.hrsa.gov><http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>

- **Primary Service Site:** _____
Practice Address: _____
Town: _____ State: _____ Zip: _____ County: _____
Work Phone: _____ Fax #: _____
Ambulatory direct patient care: _____Hrs.
Clinical services at an alternating setting: _____Hrs.
Practice administrative duties at site: _____Hrs.
On-Call: _____Hrs.

▪ **Secondary Service Site:**

Practice Address: _____
 Town: _____ State: _____ Zip: _____ County: _____
 Work Phone: _____ Fax #: _____
 Ambulatory direct patient care: _____Hrs.
 Clinical services at an alternating setting: _____Hrs.
 Practice administrative duties at site: _____Hrs.
 On-Call: _____Hrs.

▪ **Name of Employer if different from Primary Practice Site:**

Employer Address: _____
 Town: _____ State: _____ Zip: _____ County: _____
 Work Phone: _____ Fax #: _____
 Contact Person for Loan Repayment Application: _____ Title: _____
 Phone #: _____ E-mail: _____

- Enter direct patient office hours (include administrative time), do not include travel time, teaching, research or time spent "on call".

Day	Time (Start and End)		Day	Time (Start and End)	
Monday	AM:	PM:	Tuesday	AM:	PM:
Wednesday	AM:	PM:	Thursday	AM:	PM:
Friday	AM:	PM:	Saturday	AM:	PM:
Sunday	AM:	PM:			

- Participants agree to charge for services at the usual and customary rates prevailing in the primary care service area, except the patients unable to pay the usual and customary rates shall be charged a reduced rate according to the service site's sliding-fee-schedule based on poverty level or not charged. YES NO

If No, Please Explain: _____

- As a participant do you agree not to discriminate on the patient's ability to pay for care or the payments source, including Medicare and Medicaid. YES NO If No, Explain: _____

▪ **If you answered yes to any of these questions below, attach a detailed explanation to the application.**

a. Do you have a judgment lien against your property for a debt to the United States? YES NO

b. Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? YES NO

c. Has your medical/certification license ever been suspended or revoked? YES NO When? _____
 Reason for suspension/revocation: _____

d. Are any professional disciplinary actions pending? YES NO Date: _____

Reason: _____

e. Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws? YES NO When: _____

Reason: _____

LIST REMAINING LOAN EXPENSES FOR MEDICAL PROFESSIONAL EDUCATION THAT IS OUTSTANDING

*Attach copies of all outstanding medical and/or dental educational loan balances from the month previous to, or month of, this application; education loan balances not received will not be considered. N.H Loan Repayment will not cover Perkins Loans.

Lender Name	Account #	Original Amt. of Loan at Time of State Contract	Current Balance Due	Balance Due Date	Monthly Payment
	Total				

- Amount you are requesting from the State Loan Repayment Program for your extension: \$_____

Note: Please provide this information to your employer so that they have an idea what amount of matching funds might be needed. See information on web site for possible loan repayments for full-time or part-time health care providers.

- If your service site is located in a Health Professional Shortage Area (HPSA), Mental Health Shortage Area (MHPSA) or a Dental Health Professional Shortage Area (DHPSA) in New Hampshire, have you applied for a federal loan repayment program through the National Health Service Corp (NHSC) for this year? :
 YES NO

If yes, Approved YES NO Pending Decision, When: _____ If not approved, please provide letter from NHSC with this application. <http://nhsc.hrsa.gov>

- Where did you hear about the State Loan Repayment Program: School Employer Co-Worker Internet State Web-Site Other _____

CERTIFICATION BY APPLICANT: (Notary Required)

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in immediate disqualification from participation in this program. Any person who knowingly makes a false statement or misrepresentation in this loan application repayment transaction fraudulently obtains repayment for a loan, or commits any other legal action in connection with this transaction is subject to repaying any amount received from this program plus interest. I have read this statement and understand its contents.

Applicant Signature: _____ Date: _____
 Must be signed on date of notary

Witness: _____ Date: _____
 Notary Public or Justice of the Peace

SEAL

New Hampshire State Loan Repayment Program (SLRP)
(Employer Questionnaire, Contractor Continuation Application)

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- The option to extend the contract is contingent upon satisfactory delivery of services, available funding, remaining loan obligation of the Contractor, agreement of the parties and approval of the Governor and Council.

To learn more about the State Loan Repayment Program you may go to our web site at:
<http://www.dhhs.nh.gov/DHHS/RHPC/default.htm>

APPLICANT INFORMATION (Please print or type and respond to all questions)

- Name of Loan Repayment Applicant: _____
Last First
- Applicants Discipline at Practice Site: _____
- Service Site(s) Name: _____
- Is this applicant considered full-time or part-time with the employer and/or practice site? F/T P/T
- Does this applicant have a current and unrestricted N.H. License/Certification to practice in their field in New Hampshire? YES NO If no, please explain: _____
- How long employed with the employer? _____ Yrs. _____ Mos.
- Does the applicant have a current contract/employment agreement with the employer? YES NO
If yes, expires on: ____/____/____
- How many hours per week do you expect the participant to work in a primary care, mental health or oral health setting at the approved service site(s), during normally scheduled office hours? _____ Hrs.

- How many hours per week do you expect the applicant to provide inpatient care to patients of the approved service site, or providing clinical services in alternative settings (e.g., hospitals, nursing homes, shelters) as directed by the approved service site(s). ____Hrs.
- How many hours per week do you expect the applicant to provide practice related administrative duties? ____Hrs.
- How many hours per week do you expect the applicant to provide on call services during a regular week: ____Hrs.
- Is this applicant going to provide any teaching or research duties while employed at this practice site during the week? YES NO If yes, how many hours out of week: ____Hrs.
- Is this applicant's employment contingent on obtaining a state loan repayment? YES NO
If yes, please explain: _____
- Does this applicant speak a language other than English that may be significant to the practice site location and its patients? YES NO Language: _____

EMPLOYER INFORMATION

Name of Employer Organization: _____

Street Address _____

City: _____ State: _____ Zip: _____ County: _____

Contact Person HR: _____ Title: _____

E-Mail: _____ Ph: _____ Fax: _____

CEO/President/Exec Director of Organization: _____ Title: _____

- Type of Practice: (please check one)

<input type="checkbox"/> Fed. Qualified Health Center (FQHC, L-A-L) <input type="checkbox"/> DPHS Funded Clinical Health Center <input type="checkbox"/> Rural Health Clinic <input type="checkbox"/> Critical Access Hospital	<input type="checkbox"/> Dental Program/NHDPHS/Oral Health Program <input type="checkbox"/> Dental Clinic <input type="checkbox"/> Public, Not For Profit <input type="checkbox"/> Private, For Profit <input type="checkbox"/> Other _____
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- Please provide the Dental Program(s) which is contracted under the N.H. Public Health Services/Oral Health Program: Name(s): _____ Contract Expiration Date(s): _____

- The service site(s) is located in which federal designed shortage areas: HPSA MHPSA DHPSA MUA MUP EMUP Non-designated
<http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx>

- Is there a sliding-fee-schedule in place, including free care at the practice site(s)? YES NO
(If no, what does the practice site offer for discounted rates? Please submit information)

- Posted in Waiting Room? YES NO

- If not posted, available at receptionist/administration desk for the public to view? YES NO

- If No, how is it available to patients? _____
(Please provide copy of employer's discounted rates and policy for using the discounted rates)

- Do you accept all patients regardless of method of payment, including Medicaid, Medicare assignment and ability to pay? Yes No If No, explain: _____

- Is there any limit on the number of patients seen by the applicant & practice site(s) in regards to the uninsured or underinsured patients? YES NO If yes, explain: _____
- Is there any limit on the number of patients seen by the applicant & practice site(s) in regards to Medicare and Medicaid patients? YES NO If yes, explain: _____

- Describe your payor mix in the last 6 months as % of revenue at the service site that the applicant will or has been employed. **(Required for scoring purposes of application)**

Uninsured Patient: _____%

Underinsured Patient: _____%

Medicaid: _____%

Medicare: _____%

Bad/Debt: _____%

State's Children Health Program: _____%

Other: _____%

➤ The NH State Loan Repayment Program gives higher priority to applications for which 50% employer and/or community matching funds are available, as this leverages State funds to meet the needs of more communities. The State and local matching funds will be paid out over the term of the contract. Only if funds are available, or in areas of extremely high need, will contracts be funded with less than a 50% match. These applications will be reviewed on the basis of date of submission of completed application, documentation and in-house scoring based on program priorities. In addition, applicants employed full-time will be given higher priority than applicants who are employed part-time. At no time will an application be approved if the eligible practice site is not in a continued healthcare shortage designation area within New Hampshire with the exception of the Dental Health Programs under contract with N.H. Division Public Health Services/Oral Health Program. After all priority applicants have been awarded contracts, the applicants without any match are scored based on program priorities and compete for state funding with a larger group of qualified applicants, if funding is available.

- Has the applicant discussed this extension application at length with the employer/Human Resource? Yes No If no, when will you discuss? _____
- If this applicant is awarded a state loan repayment contract with the State, has your employer and/or community budgeted funds to match 50% of the award amount for the loan repayment? Yes No
 - Amount: \$ _____

If, no, when will the employer know when the available funds will become available? _____

Person to contact: _____ Ph: _____ Ext: _____

- If unable to provide 50% of the matching funds, is the employer and/or community budgeted funds to provide a partial match of the award each year for the contract? Yes No
 - Amount of partial match: \$ _____

If, no, when will the employer know when the available partial funds will become available? _____

Person to contact: _____ Ph: _____ Ext: _____

- The employer/community is unable to provide any matching funds: Yes No

Please explain reason if no, _____

▪ **Document(s) needed with Employer Portion of the Application**

- Provide a copy of the Employer's Sliding-Fee-Schedule and policy/procedures.
- Written Statement describing any extenuating circumstances or hardship needs if the employer and/or community is unable to provide any type of matching funds for this applicant seeking a State Loan Repayment:
- If you wish not to provide the Employer's Questionnaire to the applicant please mail or fax to: C/o David Roberts, Workforce Coordinator, N.H. Division of Public Health Services, Rural Health & Primary Care Section, 29 Hazen Drive, 2E, Concord, NH 03301-6504.
- Please inform the applicant if you mailed or faxed the employer's questionnaire directly to the Workforce Coordinator. Thank you.
- If the employer or practice site is located in a Health Professional Shortage Area (HPSA), Mental Health Shortage Area (MHPSA) or a Dental Health Professional Shortage Area (DHPSA) in New Hampshire, we are requesting the applicant to apply first for a federal loan repayment program through the National Health Service Corp (NHSC). <http://nhsc.hrsa.gov> . Please contact the Workforce Coordinator for more details.

Print Contact Name: _____ Title: _____
Facility's Authorized Representative

Signature: _____ Date: _____
Facility's Authorized Representative

➤ If you have any questions, please contact The Workforce Coordinator at: E-mail: droberts@dhhs.state.nh.us,

Office: (603)-271-2276, Fax: (603) 271-4506.