

## Document Checklist – Massachusetts Loan Repayment Program (MLRP)

Applicant (Health Professional) Name: \_\_\_\_\_

Applications are accepted through September 30<sup>th</sup> 2016

### Application Submission

- Submit ONE completed original application, using **Blue ink** for all signatures
- Check off each applicable “Document Checklist” item as listed below
- Submit documents in the order that they appear on the checklist. This completed “Document Checklist” should be the first page to your application
- Keep a copy of the application for your records

Mail to: Nicole Watson  
MDPH – Health Care Workforce Center  
250 Washington Street, 5th Floor  
Boston, MA 02108-4619

**Use this checklist to ensure your application is complete. Incomplete applications will not be reviewed.**

- Employer and/or Practice site is not a for-profit entity
- Health Professional Information Forms complete and signed by the health professional/applicant
- Employer Information Forms – complete and signed by appropriate employer representative
- Payor Mix Information Form ( not applicable for correctional facilities)
- A copy of current qualifying loan statement(s) must include name and address of the applicant
- A copy of the health professional’s pay stub
- W-9 Form (Verification of Taxation Reporting Information)
- Electronic Payment Form and a voided check
- Essay
- A copy of the health professional’s current resume or curriculum vitae
- A copy of the health professional’s current Massachusetts professional license
- Support letter from the practice site (When practice site is different from hiring employer organization, a letter of support 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/>
- Proof of U.S. citizenship for the health professional; Provide a copy of passport or birth certificate - Required for Component A applicants
- Either proof of U.S. citizenship Provide a copy of passport or birth certificate **or** proof of legal residency (copy of both sides of the permanent resident card) Required for Component C applicants
- Component C applicants not practicing in a federally designated HPSA or MUA/P provide documentation that greater than 30% of the patients served by the site are located in federal HPSAs or MUAs

\* Not required for FQHC and correctional facility applicants

Health Professional Information Form – MLRP

Application is for:  Component A  Component C

Name: (First) (Middle Initial) (Last)

Home Address: City State Zip Code

Residence prior to health professional education (City/State):

Sex:  M  F  Other  Decline to answer

Preferred Phone #: Work Phone #:

Preferred E-mail:

Ethnicity: Are you Hispanic/Latino/Spanish?  Yes  No  Decline to answer

Race What race(s) do you most identify with?

Check all that apply:  Asian  White  
 Native Hawaiian/Other Pacific Islander  Black  
 American Indian/Alaskan Native  Decline to answer

Professional Information

Profession: (pick one) Applicants must have completed a course of study required to practice independently without supervision.

*Please select from drop-down menu* CNM Certified Nurse Midwife

Specialty: (e.g. Family Medicine) Board Certified?  Yes  No

Other professional certification(s):

School attended for health professional training: Year of graduation (YYYY):

Name of residency training program: Date of completion (MM/YYYY):

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

**Health Professional Information Form**

How did you hear about the program?

- Massachusetts Department of Public Health/Primary Care Office Website
  College/University Career Services  
 Residency  Employer  Colleague  
 Presentation at College / University  Internet Search  Other \_\_\_\_\_

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, please indicate which program and in **months** the time commitment remaining.

Time Commitment Remaining (# of Months): \_\_\_\_\_ Months

MLRP:  Yes  No

Mass League of Community Health Centers:  Yes  No

National Health Service Corp (any):  Yes  No

UMass Learning Contract:  Yes  No

Kraft Family National Center for Leadership & Training in Community Health:  Yes  No

Other (write in): \_\_\_\_\_

**Employment Information**

Practice Site Name: \_\_\_\_\_

Practice Site Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employment Start Date: \_\_\_\_\_

The # of hours you are scheduled to work per week: \_\_\_\_\_ hrs/wk

Affirm your eligibility by reviewing and initialing the following items:

<i>Statement</i>	<i>Affirmation (Initials)</i>
I, the applicant, am a United States Citizen (required for A; either US Citizen or legal permanent resident is required for C).	
I, the applicant, am a legal permanent resident (required for "C" if not a US 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 the 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 Information Form**

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**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 Applicant**

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

\_\_\_\_\_  
**Applicant (Health Professional) Signature**

\_\_\_\_\_  
**Date**

(First) \_\_\_\_\_ Middle Initial \_\_\_\_\_ (Last) \_\_\_\_\_  
**Print Name**

## Health Professional's Qualifying Loan Statement

**Applicant (Health Professional) Name:** \_\_\_\_\_

Attach a copy of your current and complete student loan statement

- Loan statement should be from the month previous to, or month of, this application
- Must include relevant full name and address
- HIGHLIGHT each outstanding loan on the loan statement(s)
- Below list each student loan dollar amount

Student loan carrier: \_\_\_\_\_ Loan amount \$ \_\_\_\_\_

**Total loan  
amount** \$ \_\_\_\_\_

Your current annual gross salary \$ \_\_\_\_\_

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

**MLRP - Health Professional Information:  
Fiscal Documents**

W-9 Form  
Electronic Funds Transfer Form

**The W-9 and the Electronic Funds Transfer forms must be included in your MLRP application.**

**W-9 Form**

A completed W-9 must be included with your application. Use the link below to download and complete the W-9:

<http://www.mass.gov/osc/docs/forms/vendorcustomer/newmass-w9.pdf>

**Electronic Funds Transfer Form**

Use the link below to download and complete the Electronic Funds Transfer form: <https://massfinance.state.ma.us/VendorWeb/eftRegisterfrm.asp>

**Essay Questions**

Essay – Required with application

**Please respond to all 3 questions, with approximately 200 words for each response. Use the designated space below to compose your response.**

1. Describe your education, practice, and other relevant experiences which you believe qualify you to work in an underserved community or with underserved populations. Please give concrete examples of what has prepared you to work with the population served by your current site.

2. Describe your patient population including health disparities experienced by that population. Describe how you as a health care provider have been or will address these disparities and /or improve the health outcomes of the patient population (e.g. community outreach / education, support groups, research).

3. The Massachusetts Loan Repayment Program prioritizes awarding individuals whose career is focused on Shortage Areas & Medically Underserved Areas/Populations, in Massachusetts (see the following links <http://www.mass.gov/eohhs/gov/departments/dph/programs/community-health/primarycare-healthaccess/healthcare-workforce-center/shortage-designations> & <http://www.hrsa.gov/shortage/>) Please describe how your experience and interest aligns with the current underserved populations in Massachusetts.

## Employer Information Form

Employer Healthcare Organization: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

Zip Code \_\_\_\_\_

Employer Contact Name: \_\_\_\_\_

Title: \_\_\_\_\_

Employer Phone #: \_\_\_\_\_

Medicaid Billing #: \_\_\_\_\_

Employer Contact Email: \_\_\_\_\_

Employer (and Practice Site, if different from employer) is a non-profit entity  Yes  No

Employer and practice sites that are for profit are not eligible for MLRP

If Applicable provide:

Type of Federal Shortage Designation: \_\_\_\_\_

Federal HPSA # / MUA #: \_\_\_\_\_ HPSA Score: \_\_\_\_\_

\* Shortage designation information can be found at: <http://www.hrsa.gov/shortage/>

Employer or Practice Site Type : \_\_\_\_\_

e.g. Health center/medical or mental health, state facility or group practice

Name of Applicant/ Health Professional: (First) \_\_\_\_\_

(Middle Initial) \_\_\_\_\_

(Last) \_\_\_\_\_

# hours /week of direct out-patient care: \_\_\_\_\_

# hours /week of non-patient care duties: \_\_\_\_\_

Describe the need for this health professional at your organization and the type of patients/population s/he will care for (eg. homeless, LGBT, linguistic). This need statement will be considered in the application review:

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

Check all that apply to the health professional's practice

Substance abuse

Elderly

Fluency in language frequently spoken in community

Oral health

Farm/Migrant workers

Rural -Must be designated by *State Office of Rural Health*

Seasonal/transient populations (specify) \_\_\_\_\_

Disability

GLBT

Mental health

Homeless

HIV/AIDS

## Employer Information Form

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

<i>Statement and Affirmation</i>	
Health professional applicant will provide services in a public or a non-profit organization that holds any necessary MDPH licenses. <i>For-profit employers or practice sites are not eligible.</i>	
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.	
Applicant 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).	
A support letter from the employment site if different than the hiring employer organization (see the section Obligations of the Employer Healthcare Organization in the Program Guide) is attached, if appropriate.	

The applicant Employer Healthcare Organization certifies that it meets the eligibility requirements and has provided truthful information regarding the employment of the applicant 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 applicant's current annual gross salary: \$\_\_\_\_\_

As a representative of \_\_\_\_\_ I recommend this applicant for the  
MLRP (Employer Healthcare Organization)

SIGNATURE OF AUTHORIZED REPRESENTATIVE:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Full Name - Legibly

\_\_\_\_\_  
Title

## Employer Information Form

### Payer Mix Information

Provide the following patient payer mix percentage. This payer mix information should come from agency billing or financial data.

Health insurance options for low income residents at <https://www.mahealthconnector.org/>.

Name of site where health professional will/does practice	
	% of Patient Population
Medicaid ( <i>MassHealth</i> ) only	
Medicaid /Medicare Dual Eligible	
Commonwealth Care	
Health Safety Net (Free Care)	
Commonwealth Choice	
Children's Medical Security	
Medicare only	
Self Pay	
Other Uninsured	

Note from where the above data was derived, and the time period it represents e.g. calendar year.

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Signature of Authorized Representative:

\_\_\_\_\_

Signature

\_\_\_\_\_

Print Full Name - Legibly

\_\_\_\_\_

Print Title