ARIZONA STATE LOAN REPAYMENT PROGRAMS

INITIAL APPLICATION

Mail completed *Application* to:

Arizona Department of Health Services
Bureau of Health Systems Development
Attn: Loan Repayment Program Manager
150 N 18th Ave Suite 300
Phoenix, Arizona 85007

Please direct all inquiries to:
Ana Roscetti, MPH
PH: 602-542-1066
FX: 602-542-2011
ana.lyn.roscetti@azdhs.gov

****Be sure to include copies of requested additional information****

ARIZONA STATE LOAN REPAYMENT PROGRAMS
INITIAL APPLICATION

Please indicate the program you wish to participate in:

☐ PRIMARY CARE PROVIDER LOAN REPAYMENT PROGRAM
(PUBLIC, PRIVATE NON-PROFIT PROVIDERS)

☐ RURAL PRIVATE PRIMARY CARE PROVIDER LOAN REPAYMENT PROGRAM
(RURAL PRIVATE PRACTICE PROVIDERS)

I am a: ☐ **FULL-TIME PROVIDER (Working at least 40 hours per week)**

☐ **HALF-TIME PROVIDER (Working at least 20 hours per week)**

I am a: ☐ **New applicant**

☐ **Returning applicant (participated previously and completed at least two years)**

SECTION I. PERSONAL INFORMATION

Name_____
(Last) (First) (Middle Initial)

Social Security Number: _____ Date of Birth: _____
(Please send copy of Social Security card) (Month/Day/Year)

U. S. Citizen? Yes____ No _____ Please attach a copy of your birth certificate, a U.S. passport, or naturalization papers.

Place of Birth (City and State or Country if outside the United States) _____

Home Address:_____

E-mail address:_____ Home:_____ Cell: _____

Are you a resident of Arizona? Yes _____ No _____
If yes, how long have you lived in Arizona? _____

Indicate Your Race/Ethnicity (Mark all that applies):
a. Race
____American Indian or Alaskan Native ____ Black
____Asian ____ White
____Pacific Islander ____Native Hawaiian

b. Ethnicity (Mark only one)
____Hispanic or Latino ____Non-Hispanic or Latino

Discipline/Degree:

_____ Physician _____ MD_____ DO
_____ Dentist
_____ Nurse Practitioner
_____Clinical Psychologist
_____Marriage and Family Therapist
_____Physician Assistant
_____Certified Nurse Midwife
_____Clinical Social Worker
_____Professional Counselor
_____Pharmacist

Specialty:

____ Family Medicine
____ OB/GYN
____ Women's Health
____ Internal Medicine
____ Pediatric
____ Psychiatry
____ Geriatrics
____ Adult Medicine

SECTION II. EDUCATION AND CERTIFICATIONS

****PLEASE PROVIDE COPIES OF ALL LICENSES, CERTIFICATES, AND A CURRENT CURRICULUM VITAE****

A. Identify the professional school from which you received your graduate professional degree/certificate.

Name of School:_____

Location of School:_____
(City) (State)

In what year did begin your work for this degree/certificate:_____

In what year did you receive this degree/certificate:_____

B. Post-Graduate Professional Training:

Name of School:_____

Location of School:_____
(City) (State)

In what year did begin your work for this degree/certificate:_____

In what year did you receive this degree/certificate:_____

For **physicians and dentists**, have you completed a residency program? Yes_____ No_____
If yes, provide the following information:

Name and location of the professional residency program from which you received your training:

_____
(Name of Program)

_____
(City) (State)

Begin Date:_____ Completion Date:_____
(Month/Year) (Month/Year)

For **Geriatric physicians**, have you completed a fellowship or certification program in Geriatrics?

Yes ____ No _____

If yes, provide the following information:

Name and location of the fellowship or certification program from which you received your training:

_____
(Name of Program)

_____
(City) (State)

Begin Date:_____ Completion Date:_____
(Month/Year) (Month/Year)

C. Undergraduate Education:

Name of School:_____

Location of School:_____
(City) (State)

Degree_____ Major (Area of Concentration)_____

Begin Date:_____ Completion Date:_____
(Month/Year) (Month/Year)

D. Licensing/Certification:

Are you currently holding a permanent license in the State of Arizona? Yes_____ No_____

If no, when do you plan to take the examination for licensure? _____

Please describe any license restrictions:_____

_____

_____

Certifications (Including Board Certification):

For **physicians and dentists**, are you Board certified? Yes _____ No_____

***If not yet board certified, are you Board eligible? Yes _____ No_____**

If Board eligible, please send a copy of your acceptance letter from the examining authority.*

For Advance Practice Providers (PA and NP including Nurse Midwives, do you have a national certification to practice?

Yes _____ No _____

Type of Certificate:_____

State of Certification:_____ Certificate Number:_____

Date of Original Certification:_____Current Expiration:_____

For Behavioral Health Providers (including PA and NP practicing in behavioral health), do you have a national or state certification to practice? Yes _____ No _____

Type of Certificate:_____

State of Certification:_____ Certificate Number:_____

Date of Original Certification:_____Current Expiration:_____

For Pharmacists, do you have a national certification to practice? Yes _____ No_____

Type of Certificate:_____

State of Certification:_____ Certificate Number:_____

Date of Original Certification:_____Current Expiration:_____

Please describe any certification restrictions:_____

_____

SECTION III. EXISTING OR PRIOR COMMITMENTS

- Do you have an existing professional service obligation to a Federal, State, or other entity? *** Yes_____No_____

*** Other professional service obligations that preclude an applicant from being eligible for the LRP include, but are not limited to, an active duty military service obligation, National Health Service Corps (NHSC) Loan Repayment Program (LRP), NHSC Scholarship Program, Nurse Corps LRP or Scholarship Program obligation, unless that service obligation will be completely satisfied before the loan repayment contract begins.

If yes, Name of Program: _____

Contact Person:_____

Contact Telephone Number: _____

Complete Contact Address: _____

_____

Expected End Date of Obligation:_____

NOTE: If deemed eligible for LRP, the applicant must submit documentation that the professional service obligation has been completed prior to beginning the LRP contract.

- Are you delinquent on any financial obligation (i.e., taxes, student or home mortgage loans, or child support**)?

  Yes_____ No_____

  * In keeping with the President's Executive Orders concerning compliance with child support orders, all applicants must be current on all ordered support payments.

  Yes_____ No_____

- Are you delinquent on paying state taxes? Yes_____ No_____
- Are you subject to any judgment liens for a debt to a federal agency? Yes_____ No_____
- Have you defaulted on any health professional service obligation? Yes_____ No_____

  If yes, Name of Program:_____

  Contact Person:_____

  Contact Telephone Number:_____

  Complete Contact Address:_____

  Description of Default:_____

  _____

  _____

- Have you defaulted on the following:

  ☐ Yes ☐ No A Federal income tax liability

  ☐ Yes ☐ No Any federally-guaranteed or insured student or home mortgage loans

  ☐ Yes ☐ No A Federal Health Education Assistance Loan

  ☐ Yes ☐ No A Federal Nursing Student Loan

  ☐ Yes ☐ No A Federal Housing Authority Loan

SECTION IV. SERVICE TO THE UNDERSERVED POPULATIONS

Do you have experience serving the medically underserved areas or populations? Yes ____ No____

If yes, please list below starting with your most recent experience. Please attach a written and signed statement from an authorized individual from the service site, government agency, accredited educational institution or non-profit organization where services were provided.

Start and End Date	Name of Organization/ Service Site	Address	Site Type**	HPSA or MUA designation number	Contact Person/ Phone Number	Number of Hours	Service Certification Letter attached? (Yes or No)

**Site Types may be one of the following: FQHC, FQHC-LA, Tribal, IHS, RHC, CAH, State Entity, Federal Entity, Other Non-Profit, Private Practice.

Please attach a separate sheet if needed.

SECTION V. LOAN INFORMATION

Please complete this form for each loan you wish to have repaid under the Arizona State Loan Repayment Program. There is a limit of three lenders that will be repaid per contract.

Applicant's Name (Last, First, Middle) Applicant's Social Security No.

Applicant's Complete Address Applicant's Telephone No.

QUALIFYING LOANS (Please attach a written statement from the lender certifying that the loan is a used for education and reasonable living expenses only. Please attach the most recent billing statement for each loan)

LENDER 1: Percent of Quarterly Loan Repayment: _____

Lender's Name Loan Account No.

PAYMENT Address of Lending Institution Lender's Telephone No.

Was the loan sold? (If you are not sure, check with your lender) If "yes," give the secondary loan holder's name and full address. Yes_____ No_____

Original Date of Loan:_____ Original Amount of Loan: $_____

Current Balance (Principal & Interest): $_____ as of (date)_____ Interest Rate _____

Purpose of loan as Indicated on the Loan Application:_____

Type of Loan: _____

Loan in Default? Yes_____ No_____ Date of Default: _____

Is loan under a Federal Court Judgment? Yes_____ No_____ Date of Judgment _____

* * * * * * * * * * * * * *

LENDER 2: Percent of Quarterly Loan Repayment: _____

Lender's Name Loan Account No.

PAYMENT Address of Lending Institution Lender's Telephone No.

Was the loan sold? (If you are not sure, check with your lender) If "yes," give the secondary loan holder's name and full address. Yes_____ No_____

Original Date of Loan:_____ Original Amount of Loan: $_____

Current Balance (Principal & Interest): $_____ as of (date)_____ Interest Rate _____

Purpose of loan as Indicated on the Loan Application: _____

Type of Loan: _____

Loan in Default? Yes_____ No_____ Date of Default: _____

Is loan under a Federal Court Judgment? Yes_____ No_____ Date of Judgment _____

* * * * * * * * * * * * * *

LENDER 3: Percent of Quarterly Loan Repayment:_____

_____

Lender's Name Loan Account No.

_____

PAYMENT Address of Lending Institution Lender's Telephone No.

Was the loan sold? (If you are not sure, check with your lender) If "yes," give the secondary loan holder's name and full address. Yes_____ No_____

Original Date of Loan: _____ Original Amount of Loan: $_____

Current Balance (Principal & Interest): $_____ as of (date)_____ Interest Rate _____

Purpose of loan as Indicated on the Loan Application:_____

Type of Loan: _____

Loan in Default? Yes_____ No_____ Date of Default: _____

Is loan under a Federal Court Judgment? Yes_____ No_____ Date of Judgment _____

* * * * * * * * * * * * * *

FOR CONSOLIDATED EDUCATIONAL LOANS – If undergraduate and graduate education loans have been **consolidated**, submit of an itemized breakdown of the consolidated loans obtained from the lender or from the National Student Loan Database (NSLD) established by the U.S. Department of Education.

Certification by Applicant Borrower and Release of Loan Information

I hereby certify to the accuracy of the above information and apply to enter into an agreement with the State of Arizona for repayment of all or the appropriate portion of the educational loan(s) listed herein. I further certify that this/these loan(s) were incurred solely for the costs of medical education, including reasonable living expenses. I hereby authorize the lender, be it government or financial institution, named in Section VII to release information about the loan(s) listed in Section VII to the administrators of the Arizona Loan Repayment Program.

Legal Signature of Applicant: _____ Date: _____

* * * * * * * * * * * * * * * * * *

SECTION VI. CERTIFICATION and AUTHORIZATION

1. I hereby certify that, to the best of my knowledge, the loan(s) identified in the loan information form is/are educational loan(s), incurred solely for the costs of undergraduate or graduate education, including reasonable living expenses, leading to a degree in the health profession and specialty indicated in Section I of this application; and that the loan amounts do not reflect consolidated loans for other purposes.
2. I hereby certify that I am applying to enter into a contract with the state of Arizona for repayment of all or part of the educational loan(s) listed in this application.
3. I hereby certify that I will accept Medicare, Medicaid (AHCCCS), and the Health Insurance Marketplace Qualifying Health Plan assignment and rates.
3. Except for a provider working at a free clinic or a state or federal prison, I hereby certify that I will implement/utilize a sliding fee scale
4. I hereby certify that I will treat patients regardless of their ability to pay.
5. I hereby certify that I will not discriminate, and
6. I hereby certify that I have read and understand the default provision as specified in A.R.S. 36-2172 or A.R.S. 36-2174: a participant in the primary care provider or rural private primary care loan repayment program who breaches the loan repayment contract by failing to begin or to complete the obligated services as specified in the contract will be in default of their contract and will liable for liquidated damages in an amount equivalent to the amount that would be owed for default under the Federal Grants to States for Loan Repayment or as determined and authorized by the Department.

AUTHORIZATION FOR SUPPLEMENTAL INFORMATION REQUEST
I hereby authorize the Arizona Department Health Services to request and obtain supplemental information from me regarding my application. _____Initial

PRIVACY ACT RELEASE AUTHORIZATION
I hereby authorize the U.S. Department of Health and Human Services (DHHS) and/or the Department of Defense to disclose any information contained in its files pertaining to my participation in the Public Health and National Health Service Corps Scholarship Training Program, the National Service Corps Scholarship Program, the Physician Shortage Area Scholarship Program, the National Health Service Corps Loan Repayment Program, the Nursing Education Loan Repayment Program, the Community Scholarship Program, the State Loan Repayment Program, or U.S. military service to the administrators of the Arizona State Loan Repayment program, a DHHS grantee under Section 338I of the Public Health Service Act. _____Initial

PRIVACY ACT RELEASE AUTHORIZATION
I hereby authorize the Arizona Department Health Services to disclose any personal information such as name, date of birth, Social Security number, and other confidential information such as account numbers, for the purpose of verifying all information presented in this application. _____Initial

PRIVACY ACT RELEASE AUTHORIZATION
I hereby authorize the Arizona Department of Economic Security to disclose any information related to child support payments and delinquencies to the Arizona Department of Health Services for the purpose of verifying child support information as per Executive Order 13019-Supporting Families: Collecting Delinquent Child Support Obligations. _____Initial

WARNING: *Any person who knowingly makes a false statement or misrepresentation or material omission in this loan repayment application, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment. I have read this statement and understand its contents as true and accurate.* _____Initial

I hereby certify that, to the best of my knowledge, the information contained in this application is accurate and hereby authorize the Arizona Department of Health Services or its designee to verify all information presented.

Typed or Printed Name: _____

Signature: _____ Date: _____

State of)
)
County of)

The foregoing instrument was acknowledged before me this _____day of_____.

_____ My Commission Expires:_____
Notary Public