



ARIZONA STATE LOAN REPAYMENT PROGRAM PRIMARY CARE PROVIDER APPLICATION

Mail completed *Provider* and *Service Site Applications* to:

Arizona Department of Health Services
Bureau of Health Systems Development and Oral Health
Attn: Loan Repayment Program Manager
1740 W. Adams Street, Room 205
Phoenix, Arizona 85007

Direct all inquiries to:
PH: 602-542-1219
FX: 602-542-2011
vallef@azdhs.gov or
jamest@azdhs.gov

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

A. Identify the professional school from which you received your 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:

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)

Have you completed an Internship? Yes _____ No _____ If yes, provide the following information:

Name and location of the organization/facility where you performed your internship:

(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? _____

Do you hold a license in any state other than Arizona? Yes _____ No _____

If yes, please provide the following information:

State of Licensing: _____ License Number: _____

Date of Original Licensure: Start: _____ Current Expiration: _____

Please describe any license restrictions: _____

Certification (Including Board Certification):

Board certified? Yes _____ No _____

For PAs, NPs and NMs, do you have 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: _____

If not yet board certified, please send a copy of your acceptance letter from the examining authority.

SECTION III. PROFESSIONAL EMPLOYMENT EXPERIENCE

Please provide the following information. List the most recent or current employer first.

(Employer and Name of the Executive Director/Senior Manager)

(Site Name) _____ Dates employed _____

(Street Address)

(City) _____ (State/Province) _____ (Zip Code)

Telephone Number: (____) _____ May we contact? _____

(Employer and Name of the Executive Director/Senior Manager)

(Site Name) _____ Dates employed _____

(Street Address)

(City) _____ (State/Province) _____ (Zip Code)

Telephone Number: (____) _____ May we contact? _____

(Employer and Name of the Executive Director/Senior Manager)

_____ Dates employed _____
(Site Name)

(Street Address)

(City) (State/Province) (Zip Code)

Telephone Number: (____)_____ May we contact? _____

If you would like to provide additional employment experience, attach information on a separate piece of paper, with your name and social security number at the top.

SECTION IV. PROFESSIONAL REFERENCE

Please provide the following information about three professional references not provided elsewhere in this application.

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (____) _____
(Telephone)

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (____) _____
(Telephone)

Reference Name: _____ Title: _____

Complete Address: _____

(City) (State) (Zip Code) (____) _____
(Telephone)

SECTION V. 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 Education LRP or Nursing Scholarship Program obligation, unless that service obligation will be completely satisfied before the contract has been signed.

If yes, Name of Program: _____
Contact Person: _____
Contact Telephone Number: () _____
Complete Contact Address: _____

Terms of obligation: _____

- 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.

- Are you subject to any judgment liens for a federal debt to the United States? Yes _____ No _____
- Are you in default of any professional service obligation? **** Yes _____ No _____

**** e.g. have you failed to begin or complete service or failed to fulfill service requirements.

If yes, Name of Program: _____
Contact Person: _____
Contact Telephone Number: () _____
Complete Contact Address: _____

Terms of obligation: _____

SECTION VI. SERVICE SITE COMMITMENT

Attach a copy of the signed employment contract for the current or prospective service site. Contract must indicate that full-time (40 hours minimum*), primary care services will be delivered at the approved service site for a minimum of 24 months.

Service Site: _____

Service under the employment contract is to commence on _____ and end on _____

*Unless an obstetrician or nurse midwife, ASLRP providers must work a t least 32 of the minimum 40 hours per week providing ambulatory care services at the approved service site during scheduled office hours. If an obstetrician or nurse midwife, ASLRP providers must work a t least 21 of the minimum 40 hours per week providing ambulatory care services at the approved service site during scheduled office hours.

SECTION VII. LOAN INFORMATION

Please copy and complete this form for each loan you wish to have repaid under the Arizona State Loan Repayment Program. This form must be sent to each of your lenders for verification. If more than one loan, please indicate any preference you may have for repayment. There is a limit of three lenders that will be repaid per contract. If no preference is indicated, the quarterly payments will be split evenly among the vendors. Please send a copy of your most recent billing notice for documentation.

1. Applicant's Name (Last, First, Middle) _____ 2. Applicant's Social Security No. _____

3. Applicant's Complete Address _____ 4. Applicant's Telephone No. _____

4. (Name of Lending Institution) _____ 5. Loan Account No. _____

6. Full Address of Lending Institution _____ 7. Lender's Telephone No. _____

8. 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 _____

9. Original Date of Loan: _____ 10. Original Amount of Loan: \$ _____

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

12. Purpose of loan as Indicated on the Loan Application: _____

13. Type of Loan: _____

14. Loan in Default? Yes _____ No _____ Date of Default: _____

15. Is loan under a Federal Court Judgment? Yes _____ No _____ Date of Judgment _____

FOR CONSOLIDATED UNDERGRADUATE AND GRADUATE EDUCATION LOANS – If undergraduate and graduate education costs have been consolidated, attach a copy of the loan documents for health professions education costs that were consolidated into the new loan.

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 in Section VII 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: _____

Social Security Number of Applicant: _____

Lending Institution's Certification

The undersigned states that, to the best of his or her knowledge, the loan identified in Section VII is a bona fide and legally enforceable commercial, state, or government educational loan made for the purpose of meeting the borrower's costs of attending undergraduate school or graduate school in a health profession.

Signature: _____ Date: _____

Government/State or Bank Authorized Official

Title: _____

SECTION VIII. CERTIFICATION

1. I hereby certify that, to the best of my knowledge, the loan(s) identified in this application 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 (AZ AHCCCS), and the State Children’s Health Insurance program (KidsCare) assignment and rates.
4. I hereby certify that I will implement/utilize a sliding fee scale and 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(J): a participant in the primary care provider loan repayment program who breaches the loan repayment contract by failing to begin or to complete the obligated services is liable for liquidated damages in an amount equivalent to twice the total uncredited amount of the loan repayment contracted for on a prorated monthly basis. The department may waive the liquidated damages provisions of this subsection if it determines that death or permanent physical disability accounted for the failure of the participant to fulfill the contract. The department may prescribe additional conditions for default, cancellation, waiver or suspension that are consistent with the National Health Service Corps loan repayment program (42 Code of Federal Regulations sections 62.27 and 62.28).

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.

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.

(Initials of applicant)

I hereby certify that, to the best of my knowledge, the information contained in this application is accurate and 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 _____.

Notary Public

My Commission Expires: _____

How Did You Find Out About This Program?

_____ Program Flyer

- _____ National Health Services Corps
- _____ Web search
- _____ Practice Site
- _____ School/College Financial Aid Office
- _____ Friend
- _____ Professional Organization (Please specify)_____
- _____ Other (Please specify)_____

TIMELINES FOR SUBMITTING COMPLETED APPLICATION PACKAGE:

Submit application package by:	To be considered for a contract term to commence:
March 15	July 1
June 15	October 1
September 15	January 1
December 15	April 1

CHECKLIST

Have you included all required documentation?

- Primary care provider application (notarized)
- Service site application (notarized)
- Substitute W-9 form (see website or contact office)
- Copy of Social Security card
- Copy of birth certificate, U.S. Passport, or naturalization papers
- Copy of current CV
- Copy of Arizona medical license(s)
- Copy of educational certificate(s)
- Copy of board certification or acceptance letter from examining authority
- Copy of employment contract (must include):
 - address of site where services are to be provided
 - be employed full time (40 hours/week)
 - be contracted for 24 month minimum (for initial contract)
- Copy of service site's sliding fee schedule and policy/procedures for its use
- Loan verification from lending institution, p. 7 (original signature required)
- Copies of most recent billing statement for each loan to be repaid
- If more than one loan, a statement from provider of how payments should be disbursed to each lender.