OREGON OFFICE OF RURAL HEALTH AND THE OREGON HEALTH AUTHORITY

MEDICAID PRIMARY CARE LOAN REPAYMENT PROGRAM APPLICATION

The Medicaid Primary Care Loan Repayment Program offers loan repayment to physicians (family medicine, general practice, internal medicine, geriatrics, pediatrics or OB/GYN), nurse practitioners (adult health, women's health care, geriatrics, pediatrics, psychiatric mental health, family practice or nurse midwifery), physician assistants (family medicine, general practice, general internal medicine, geriatrics, pediatrics or OB/GYN), dentists (general or pediatric), expanded practice dental hygienists, psychiatrists (general, child/adolescent or geriatric), clinical psychologists, licensed clinical social workers and marriage/family therapists practicing in Oregon. The intent of the program is to support professional health care providers practicing in Oregon's areas of unmet health care need to serve the Medicaid population in that area.

Qualifying practice sites include rural hospitals (defined in ORS 442.470), federally certified Rural Health Clinics, Federally Qualified Health Centers, sites providing primary care services in an approved Health Professional Shortage Area (HPSA) as defined by the Health Resources and Services Administration (HRSA) or sites providing primary care services in an underserved area (subject to approval).

Please see the map of Oregon HPSAs, as well as a list of Rural Health Clinics, a list of Rural Hospitals, and a list of Federally Qualified Health Centers for clarification of some eligible sites.

Award Information:
In exchange for qualifying service, participants may receive funds to repay qualifying graduate-level, (or for expanded practice dental hygienists, undergraduate-level) loan debt. Awards will be calculated based on the balance owed on qualifying loans upon program entry.

Participants commit to a minimum of 3 years and receive an annual tax free award of 20% of qualifying loan debt balance, up to $35,000 for full time service. Part time service providers commit to a minimum of 5 years and receive an annual tax free award of 10% of their qualifying loan debt balance, up to $17,500.

Once the first payment from this program is received and processed, the participant must satisfy the minimum practice requirement or pay a penalty.

Is anything needed in addition to this application?
Yes. Attach a current copy of your curriculum vitae or resume detailing your employment history and education background, as well as a copy of your contract or memorandum of agreement to practice in a qualifying practice site. In addition, please provide the most recent statement displaying your educational loan balance.

Who may apply?
All applicants must be practicing at a qualified practice site. Applicants must show an employment contract documenting that their employment at their site began within the previous 24 months from the date of application or an agreement to begin practice with a qualifying practice site within 120 days from the date of the application. Applicants must agree to serve Medicaid patients at the same approximate rate of Medicaid coverage in their service area, up to a maximum requirement of 15% of patient mix.

Applicants cannot currently be participating in the National Health Services Corps (NHSC) Loan Repayment or Scholarship Program, Nursing Corps or the State Loan Repayment Program (SLRP).

All applicants must have documentation, or proof of having applied for, an unrestricted license to practice in Oregon within their specified discipline.

Applications are accepted on an ongoing basis. Awards are made on a quarterly basis.

Are all eligible applicants assured participation?
No, however all applicants will be considered and priority may be given for those serving in areas with a HPSA score of 10 or higher, those providing services in or those having an affiliation with a recognized Patient Centered Primary Care Home (PCPCH), as well as applicants that are contracted to begin working at a qualified practice site within four months from the date of their application.

Application Checklist

- ☐ Completed and signed MPCLRP Application
- ☐ Educational Loan Balance Statement
- ☐ CV/Resume
- ☐ Copy of Unrestricted License to Practice in Oregon
- ☐ Employment Agreement

Return the application form and all required attachments to:

OHSU OFFICE OF RURAL HEALTH

ruralworkforce@ohsu.edu
or
Fax: (503) 494-4798

Questions: (503) 494-4450 Toll Free: (800) 674-4376

MEDICAID PRIMARY CARE LOAN REPAYMENT PROGRAM APPLICATION

1. BIOGRAPHICAL INFORMATION

NAME_____

SSN_____ BIRTH DATE_____

ADDRESS_____
Street *Apartment Number*

CITY_____ STATE/ZIP_____

COUNTY_____ HOME TELEPHONE_____

EMAIL ADDRESS: _____

WHAT RACE/ETHNICITY DO YOU IDENTIFY AS? (Optional)

- ☐ AMERICAN INDIAN/ALASKAN NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
- ☐ HISPANIC OR LATINO
- ☐ WHITE, NON-HISPANIC OR LATINO

2. PROFESSION / EDUCATION (Please mark one)

- ☐ PHYSICIAN as of date:_____
- ☐ PHYSICIAN ASSISTANT as of date: _____
- ☐ NURSE PRACTITIONER as of date:_____
- ☐ DENTIST as of date:_____
- ☐ DENTAL HYGIENIST (expanded practice) as of date:_____
- ☐ SOCIAL WORKER as of date: _____
- ☐ MARRIAGE/FAMILY THERAPIST as of date: _____
- ☐ PSYCHOLOGIST as of date: _____
- ☐ PSYCHIATRIST as of date:_____

Please indicate your specialty: Family Medicine

List your education that led to your health profession.

College(s) Degree/Certificate Dates Attended

_____

_____

_____

Expected Completion Date *(if in last year of program):* _____

3. PARTICIPATION IN OTHER INCENTIVE PROGRAMS

3. Have you received scholarships or loans with practice obligations? ■ **YES** ☐ **NO**

If yes, list the programs and describe the service obligation.

_____

_____

_____

4. ARE YOU CURRENTLY WORKING AT A QUALIFYING PRACTICE SITE? IF NOT, WILL YOU BEGIN PRACTICE WITHIN FOUR MONTHS AT A QUALIFYING PRACTICE SITE, FOLLOWING THE EXECUTION OF THIS AGREEMENT? ■ YES ☐ NO

If yes, please list name of site and employment start date.

_____

If no, explain why and list the date you would be able to begin practice.

Are you applying for a full time (32 hours direct patient care/week) or a part time (16 hours direct patient care/week) award? *Award preference must match your current employment contract or agreement in order to qualify for either award*

⊙ **FULL-TIME** ☐ **PART-TIME**

5. PERSONAL BACKGROUND

List all other postsecondary education.

College(s) Degree/Certificate Dates Attended

_____

_____

_____

List the communities where you have lived.

City State From (Yr) To (Yr)

_____

_____

_____

_____

Have you ever participated in an Area Health Education Center (AHEC) program? If so, please list: _____

Describe your work and life experiences and how they contribute to your ability to serve as a health practitioner in an underserved setting. Why have you chosen to serve underserved populations?

6. CAREER GOALS

Describe your career in detail as you hope it will be in **five years**. Include projects and skills:

Describe your career in detail as you hope it will be in **ten years**. Include projects and skills.

7. IS THERE ANY OTHER INFORMATION ABOUT YOU, WHICH YOU CONSIDER PERTINENT TO THE SELECTION PROCESS FOR THIS PROGRAM?

8. CERTIFICATION

I hereby declare that the information contained in this application is true and correct to the best of my knowledge. I authorize the holder(s) of my loan(s), the guarantor, or their agents to release information concerning my loan(s) to the Oregon Office of Rural Health for the purpose of verifying the amount of qualifying debt.

Signature:_____

Date:_____

PART F: EDUCATIONAL DEBT REPORTING DIRECTIONS:

 List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be completed even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete and it will not be reviewed.
 You must submit evidence of the educational debts listed below. If your loans have been consolidated, submit proof of consolidation.
 Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted. Online printouts are acceptable as long as they include all of the required information.
 You may only submit proof of debt for those loans obtained during the course of your graduate education (except for EPDHs) which led to your current license/certification as a qualified provider for this program. Please ensure all documentation shows the date of origination and/or school name for each loan reported. Make sure that the Lender Address listed below corresponds with the address to which payments are sent to. This address must also appear on the lender statements you have included in your application packet.

1. Lender Name: _____

Lender Address (send payments to): _____

City: _____State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance $ _____

2. Lender Name: _____

Lender Address (send payments to): _____

City: _____State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance $ _____

3. Lender Name: _____

Lender Address (send payments to): _____

City: _____State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance $ _____

4. Lender Name: _____

Lender Address (send payments to): _____

City: _____State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance $ _____

5. Lender Name: _____

Lender Address (send payments to): _____

City: _____State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance $ _____