

## Race and Ethnicity

How do you identify your **race, ethnicity, tribal affiliation, country of origin, or ancestry?**

Which of the following describes your **racial or ethnic identity?** Please check **ALL** that apply.

### American Indian or Alaska Native

- American Indian
- Alaska Native
- Canadian Inuit, Metis, or First Nation
- Indigenous Mexican, Central American, or South American

### Hispanic or Latino/a/x

- Central American
- Mexican
- South American
- Other Hispanic or Latino/a/x

### Asian

- Asian Indian
- Chinese
- Filipino/a
- Hmong
- Japanese
- Korean
- Laotian
- South Asian
- Vietnamese
- Other Asian

### Native Hawaiian or Pacific Islander

- Guamanian or Chamorro
- Micronesian
- Native Hawaiian
- Samoan
- Tongan
- Other Pacific Islander

### Black or African American

- African American
- African (Black)
- Caribbean (Black)
- Other Black

### Middle Eastern/Northern African

- Northern African
- Middle Eastern

### White

- Eastern European
- Slavic
- Western European
- Other White

### Other Categories

- Other (please list)  
\_\_\_\_\_
- Don't know/Unknown
- Don't want to answer/Decline

# Oregon Health Care Provider Loan Repayment for Unlicensed Mental Health Providers

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## Eligible Provider Types

Applicants must have completed a master's level or higher degree program in one of the following fields:

- Clinical Social Work
- Counseling or Clinical Psychology
- Professional Counseling
- Marriage and Family Counseling

Applicants must be registered with their respective professional board and working towards licensure at a qualifying practice site.

## Qualifying Practice Sites

An eligible provider must serve at a practice site that:

- Is located in a Health Professional Shortage Area (HPSA), or has a Facility HSPA; AND
- Is serving Medicaid and Medicare patients in no less than the same proportion of such patients in the county; AND
- Has a Site Application on file with the Oregon Office of Rural Health that is no more than 1 year old.

## Award Information:

In exchange for a service obligation, providers may receive funds to repay qualifying education loan debt. Awards are calculated based on the qualifying balance owed on loans upon program entry.

**Full time** service providers must commit to a 3 year minimum service obligation in exchange for a tax free award of 50% of their qualifying loan debt balance, up to \$35,000 per obligation year.

**Part time** service providers must commit to a 3 year minimum service obligation in exchange for a tax free award of 25% of their qualifying loan debt balance, up to \$25,000 per obligation year.

Failure to complete the minimum service obligation at a qualified practice site will result in penalties and fees pursuant to OAR 409-036-0120.

## Required Attachments

1. A current copy of your curriculum vitae or resume detailing your employment history and education background;
2. A signed copy of your contract or memorandum of agreement (including all appendixes & attachments) to practice at a qualifying practice site;
3. Statement(s) from your loan provider with detailed information on your educational loan(s);
4. Official notice of registration with appropriate licensing board;
5. Most recent official receipt of hours submitted to your board

## Applicant Qualification:

All applicants must:

- Commit to practice in a qualifying practice site; AND
- Agree to serve Medicaid and Medicare patients in no less than the same proportion of such patients in the county or other service area, as determined by the Authority up to a maximum of 50 percent with at least 25 percent of which is Medicaid; AND
- Be an eligible primary care provider type, providing outpatient care; AND
- Have registered with appropriate licensing board and working towards licensure; AND
- Not be currently participating in the National Health Services Corps (NHSC) Loan Repayment or Scholarship Program, Nursing Corps, State Loan Repayment Program (SLRP), or other service obligation

## Award Determination:

The following factors may be taken into consideration in the determination of awards:

- Providers who apply from a qualifying site located in a high scoring HPSA; AND/OR
- Providers who apply from a qualifying site located in a service area ranking below the median in the most recent Areas of Unmet Health Care Need Report; AND/OR
- Providers who apply from a qualifying site certified to meet the requirements of the National Health Service Corps; AND/OR
- Providers who practice at, or in affiliation with, a Patient Centered Primary Care Home; AND/OR
- Providers who meet specific needs identified by a community, including ethnicity, language spoken, specialty, or provider type; AND/OR
- Providers who apply from a qualifying site that is facilitating the integration of behavioral health with other health services.

## Application Checklist

- Completed and signed application
- Current educational loan documentation
- CV/Resume
- Copy of registration with appropriate licensing board
- Copy of full signed employment agreement
- Official notice of registration with appropriate licensing board
- Recent official receipt of hours submitted to your board

Return the application form and all required attachments to:

**OREGON OFFICE OF RURAL HEALTH**

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

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

**HEALTHCARE PROVIDER INCENTIVE PROGRAM LOAN REPAYMENT APPLICATION FOR  
UNLICENSED MENTAL HEALTH PROVIDERS**

**1. Biographical Information**

Name: \_\_\_\_\_

SSN: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

City: \_\_\_\_\_ State & Zip: \_\_\_\_\_

County: \_\_\_\_\_

Home Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

How do you identify (optional)?  
Please see the final page of this application for an optional demographics reporting form.

- I have completed the attached optional demographics reporting form
- I decline to complete the optional demographics reporting form

Are you fluent in a second language?  Yes  No

Note: Being fluent is defined as the ability to speak a language at a level that allows you to effectively communicate with a patient during a clinical encounter.

If yes, please list which language(s) and level of fluency:

\_\_\_\_\_

\_\_\_\_\_

**2. Profession & Education**

I have completed a masters level or higher in the field of (please mark one):

- Clinical Social Work
- Counseling or Clinical Psychology
- Professional Counseling
- Marriage and Family Counseling

Current number of licensure hours obtained

Remaining number of licensure hours

**3. Participation in Other Incentive Programs & Employment Status**

Have you received scholarships or loans with service obligations? **Yes** **No**

If yes, list the program(s) and describe the service obligation as well as dates of participation.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**4A. Employment**

Are you currently working at the qualifying practice site at which you will serve? **Yes** **No**  
If you answered "No" above, please proceed to 4B

Do you split your time between more than one practice site? **Yes** **No**  
Please list the name(s) of your qualified practice(s) site and employment start date:

\_\_\_\_\_

\_\_\_\_\_

**4B:** If not currently working at the qualifying practice site at which you will serve, explain why and list the date you will be begin practice:

\_\_\_\_\_

\_\_\_\_\_

**4C:** Are you employed full time (at least 40hrs, with 32hrs direct patient care per week) or part time (at least 20hrs, with 16hrs direct patient care per week)?  **Full-time**  **Part-time**

**5. Personal Background**

List all postsecondary education.

<u>College(s)</u>	<u>Degree/Certificate</u>	<u>Dates Attended</u>
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\_\_\_\_\_

\_\_\_\_\_

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List the communities where you have lived, starting with your hometown.

<u>City</u>	<u>State</u>	<u>From (Yr)</u>	<u>To (Yr)</u>
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\_\_\_\_\_

\_\_\_\_\_

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## Educational Debt Reporting Instructions

All spaces on this form must be completed even if the information appears on your lender statements. Any missing information will make the entire application incomplete and the application will not be reviewed.

Current lender statements must be dated within 30 days of submission and **MUST** include the **current balance, account number, your name, and the loan's date of origination and/or school name** for **each** loan reported. Online printouts are acceptable as long as they include all of the required information.

You must submit evidence of the educational debts listed below. **If your loans have been consolidated you must submit detailed documentation on the consolidation** ([please see our FAQs](#)).

Only submit proof of debt for those loans obtained during the course of your undergraduate or graduate education which led to your current license/certification as a qualified provider for this program.

The preferred file type when submitting all documentation related to your application is .PDF. ORH is able to accept .JPEG, .TIFF, or .PNG, files so long as they are attached to an email rather than imbedded. Files imbedded in emails are blocked by ORH's email firewall. **ORH is unable to accept files that can be altered (e.g. .doc & .TXT files), even if they are converted to a different file type before they are submitted** ([please see our FAQs](#)).

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: \$ \_\_\_\_\_