2020 New Application

Rural Practitioner Tax Credit

Practitioner

*Name: _____ *Social Security: _____
(Your name used on taxes)

*Email: _____ *Your daytime phone: _____

*Specialty: _____ *License number: _____

*Licensure: CRNA^ ☐ | DDS^ ☐ | DMD^ ☐ | DO^ ☐ | DPM^ ☐ | MD^ ☐ | NP ☐ | PA ☐ | OD^ ☐

***Home address** (the home address used on taxes)

_____ _____
*Street *City

_____ _____ _____
*County *State *Zip Code

***Individual adjusted gross income does not exceed $300,000 for the tax year.**

It **does not** exceed ☐ It **does** exceed ☐

(*If your 2020* ***individual*** *adjusted gross income is in excess of $300,000, you are not eligible to claim this credit for tax year 2020. The only exceptions are for a physician who practices as a general surgeon, specializes in obstetrics or specializes in family or general practice and provides obstetrical services.)*

Oregon Practice Sites

***Site 1:** _____
*Name

_____ _____
*Street *City

_____ _____
*County *Zip Code

***List the hours practiced in an average work week at this site.** An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

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Site 2: _____
Name

_____ _____
Street City

_____ _____
County Zip Code

List in the hours practiced in an average work week at this site. An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

Site 3: _____
Name

_____ _____
Street City

_____ _____
County Zip Code

List the hours practiced in an average work week at this site. An average work week is factored by dividing the monthly total hours by 4. **DO NOT LIST MONTHLY TOTALS**

Jan:	Feb:	Mar:	Apr:	May:	Jun:
Jul:	Aug:	Sep:	Oct:	Nov:	Dec:

If you have more than 3 sites, please include them formatted exactly as above on additional paper.

***** I hereby confirm that throughout the tax year I was ***willing*** to serve patients with Medicare and Medicaid coverage in the same proportion to the total number of Medicare and Medicaid recipients in the practice's county, up to 20 percent Medicare patients and 15 percent Medicaid patients.

_____ Yes _____ No

*Signature: _____

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^ *CRNA & DPM: include a letter from an eligible hospital on their letterhead verifying your personal employment or contractual status with that eligible hospital.

^ *DDS & DMD: If there is a hospital in your community, you must have a verifiable agreement with that hospital to provide emergency dental services. Please provide the following information:

_____ _____

Name of hospital (if applicable) City

_____ _____

Verification contact name Phone

The following attestations are required for dentists accepting this tax credit. Please check each one that is applicable (1 & 2 or 1 & 3).

1.____I hereby confirm my willingness to reasonably accommodate the oral health needs of patients in my rural community regardless of the source of payment for their care; AND

2.____I hereby confirm that I have a verifiable written agreement with the rural hospital in my community to treat emergency dental patients either on the hospital premises or in my operatory regardless of the source of payment for their care; OR

3. ____There is no hospital in my rural community.

^ *DO & MD: If you are on **active staff** of **any** Oregon hospital, please list:

_____ _____

Name of hospital City

^ *OD: You must have verifiable consulting privileges with an eligible rural hospital **unless** you practice a minimum of 20 hours per week or more in a Frontier county. If you **do not** practice in a Frontier county, please provide the following information:

_____ _____

Name of hospital City

_____ _____

Verification contact name Phone

Make $45.00 check payable to: Oregon Office of Rural Health

Mail check and renewal form to: Oregon Office of Rural Health
3181 SW Sam Jackson Park Rd, L593
Portland OR 97239

Required | ^ license-specific requirement on page 3