IMPORTANT

Applicants are required to submit their application themselves. Clinic staff, or other representatives, cannot submit applications on behalf of an applicant.

While providers in eligible disciplines may apply for more than one Loan Repayment Program at a time, if offered an award by more than one program, only one award may be accepted. Once a Loan Repayment program contract is in place, awardees are unable to switch programs, and must complete their service obligation before applying to other Loan Repayment programs. Examples of Loan Repayment programs include, but are not limited to, Oregon Partnership State Loan Repayment Program (SLRP), National Health Service Corps (NHSC), Oregon Health Care Provider Loan Repayment, NURSE Corps, NHSC Scholars, and/or other State, Federal, or local Loan Repayment Programs offering funds in exchange for a service obligation.

ORH

Health

Oregon Health Care Provider Loan Repayment
(A Component of Oregon's Health Care Provider Incentive Program)

The Healthcare Provider Incentive Program's loan repayment subsidy supports Oregon's health system transformation efforts to ensure an adequate supply of primary care providers providing medical or dental health care in outpatient settings in under-served areas of Oregon.

Eligible Licensed Provider Types

- MDs, DO, & NDs (family medicine, general practice, internal medicine, geriatrics, pediatrics or OB/GYN);
- NPs (family medicine, women's health care, geriatrics; pediatrics, psychiatric mental health, family practice or nurse midwifery);
- PAs (family medicine, general practice, general internal medicine, geriatrics, pediatrics or OB/GYN);
- DMDs & DDS (general or pediatric);
- Expanded Practice Dental Hygienists;
- Pharmacists

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).

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 an unrestricted license to practice in Oregon within provider's discipline; **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.

Application Checklist

- ☐ Completed and signed application
- ☐ Current educational loan documentation
- ☐ CV/Resume
- ☐ Copy of unrestricted license to practice in Oregon
- ☐ Copy of full signed employment agreement

Accommodation requests related to a disability should be made in advance to ruralworkforce@ohsu.edu, if support with completing the application is needed. Every effort will be made to provide services to requests, however submitting your request as early as possible is greatly appreciated. To best ensure our ability to provide an accommodation please contact us even if you are only considering applying.

Submitting the Application

Please submit the completed application form (see below) and all required attachments to the Oregon Office of Rural Health at ruralworkforce@ohsu.edu

For questions about the program or application, please see our program and loan documentation FAQs, or contact the Office of Rural Health at ruralworkforce@ohsu.edu or by phone at (503) 494-4450.

HEALTHCARE PROVIDER INCENTIVE PROGRAM LOAN REPAYMENT APPLICATION

Preferred Full Name : ___________________________________

Is this your legal name? ☐ Yes ☐ No

If no, please list your legal name:

____

What pronouns do you use? (select all that apply)

☐ They/Them; ☐ She/Her; ☐ He/Him; ☐ No pronouns, use my name;

☐ Don't know; ☐ Not listed (please specify): ____________

☐ I don't know what this question is asking;

☐ I don't want to answer

Last 4 of SSN: _______________________________________

Date of Birth: _______________________________________

Address: ____

City: ______________________ State & Zip: _____________

County: ____

Home Telephone: ____________________________________

Email Address: ______________________________________

What is your provider type; your license type & the date you were licensed: _______________________________________

____

Please indicate your specialty if any: ____________________

____

Please indicate your National Provider Identifier (NPI):

____

Are you currently working at the qualifying practice site at which you will serve? ☐ Yes ☐ No

Do you split your time between more than one practice site? ☐ Yes ☐ No

Full name(s) and address (es) of your qualified practice site(s) and employment start date:

____

____

____

Do you meet the programs definition of ☐ Full-time ☐ Part-time?

Full-time (providing at least 32hrs of direct patient care per week)
or
Part-time (providing at least 16hrs direct patient care per week)

List all postsecondary education.

College(s)	Degree/Certificate	Dates Attended

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:

____

____

____

Please see the final page of this application for an optional demographics reporting form.

◻ I have completed the attached optional demographics reporting form

decline to complete the optional demographics reporting form

Are you multilingual? ☐ Yes ☐ No

If yes, please list which language(s) you speak:

____

Do you have cultural knowledge and/or shared lived experience with the communities who speak these languages? ☐ Yes ☐ No

If answer is yes or no, please explain

____

____

____

____

____

____

____

Please answer the essay questions below and include as an attachment to your application. (Maximum of 750 words per question)

Question 1:

How will you advance health equity within your community and how will you leverage your education/chosen profession to support health equity amongst marginalized populations*? Provide as many examples within the word limit as possible.

Question 2:

Describe how your personal experiences with marginalized populations* outside of work settings has adequately prepared you to serve these communities within your chosen profession? Provide as many examples within the word limit as possible.

*Marginalized populations defined as communities of color, tribal communities, immigrant and refugee communities, migrant and seasonal farmworkers, LGBTQIA+ communities, persons with disabilities, and individuals living in historically under-served communities (e.g., rural and frontier communities).

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.

Full Name: ______________________________

Signature: ______________________________

Date: ______________________________

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, the loan's date of origination and/or school name, and original disbursement amount for each loan reported. Online printouts are acceptable as long as they include all of the required information. *Please note: Accounts can be made up of multiple loan tokens. So, listing each individual loan token is not needed.*

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 incurred for the education that led to you obtaining your certificate and/or degree, which was required for your current position.

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: ____

   City:________________State:____________Zip +4:________________

   Account Number:__________________Current Loan Balance: $____________

   Dates debt was incurred: ______________________________________

2. Lender Name:____

   Lender Address: ____

   City:________________State:____________Zip +4:________________

   Account Number:__________________Current Loan Balance: $____________

   Dates debt was incurred: ______________________________________

3. Lender Name:____

   Lender Address: ____

   City:________________State:____________Zip +4:________________

   Account Number:__________________Current Loan Balance: $____________

   Dates debt was incurred: ______________________________________

OREGON OFFICE ORH of RURAL HEALTH

Oregon Health Authority

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

Preferred Pronouns: ______________________________