

IMPORTANT

Providers may apply a total of 3 times to Oregon Health Care Provider Loan Repayment. Handwritten applications will not be reviewed. Applicants must use the fillable PDF, or otherwise type out their application.

Providers working in emergency care, urgent care, or inpatient settings are ineligible for Oregon Health Care Provider Loan Repayment.

If awarded though Oregon Health Care Provider Loan Repayment providers will be required to complete their service obligation at an approved practice site in Oregon. In the event of a practice failure or other extenuating circumstance an awardee needing to switch practice sites will be required to seek prior approval and submit documentation for the needed change (OAR 409-036-0090).

While medical 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.

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, dental, and behavioral health care in outpatient settings in underserved areas of Oregon.

Eligible 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;
- Psychiatrists (general, child/adolescent or geriatric);
- Pharmacists;
- Clinical Psychologists;
- Mental Health Providers (LCSWs, LPCs, LMFTs)

Qualifying Practice Sites

For loan repayment, a provider must serve at a 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 qualifying service, providers 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.

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)

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.

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 and/or oral health services with primary care.

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

Return the application form and all required attachments to:

OREGON OFFICE OF RURAL HEALTH

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

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

HEALTHCARE PROVIDER INCENTIVE PROGRAM LOAN REPAYMENT APPLICATION

1. Biographical Information

Name: _____
 SSN: _____
 Date of Birth: _____
 Address: _____
 City: _____ State & Zip: _____
 County: _____
 Home Telephone: _____
 Email Address: _____

How do you identify? (Optional, check all that apply)

- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- Hispanic, or Latino, or Spanish origin
- White

Are you bilingual? Yes No

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

2. Profession & Education (please mark one, list license type and date licensed)

- Physician _____
- Physician Assistant _____
- Pharmacist _____
- Nurse Practitioner _____
- Dentist _____
- Expanded Practice Dental Hygienist _____
- Mental Health _____

Please indicate your specialty: _____

Please indicate your National Provider Identifier (NPI): _____

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.

4. Employment

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

Please list the name(s) of your qualified practice(s) site and employment start date:

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:

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>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

6. Essay Questions

Please share why you have chosen to become a healthcare professional.

Why have you chosen to serve in your area? Describe any work and/or life experiences and how they contribute to your ability to serve as a health practitioner in a rural or urban underserved setting.

Describe your career in detail, as you hope it will be, in ten years (include projects and skills).

What is your favorite aspect of working in healthcare?

7. 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 the address to which payment is submitted** 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 graduate education (except for EPDHs) 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: \$ _____

5. Lender Name: _____

Lender Address (send payments to): _____

City: _____ State: _____ Zip +4: _____

Account Number: _____ Current Loan Balance: \$ _____