DC Department of Health
Primary Care Bureau
Health Professional Loan Repayment Program
899 North Capitol Street NE, 3rd Floor
Washington, DC 20002
P: (202) 442-9168 F: 202.442.4948 EMAIL: HPLRP@dc.gov

DC HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM APPLICATION

Provider Application for DC HPLRP

This application, with supporting documentation, must be completed by any provider interested in receiving loan repayment through the DC Health Professional Loan Repayment Program (HPLRP or the Program). The application consists of ***three sections: Applicant Profile, Recommendation Form, and Loan Information****. All three sections must be completed in order for an application to be considered complete.*

Completed applications will be scored and applicants will be notified of approval or denial into the program within 90 days of application receipt. Awards will issued in January and June.

Participation in and renewal of contracts with the DC HPLRP are dependent on available funding.

A list of provider types that are eligible for the HPLRP can be found on the Primary Care Bureau page of the DC Department of Health's Website. To be eligible for participation in the HPLRP, individuals must be employed or have a contracted offer of employment at a site that has been certified by the Program as a Service Obligation Site (SOS) and provide services (Primary Care, Mental Health or Dental) that correspond to the Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) in which the practice site is located. Certification of a site as a Service Obligation Site does not confer automatic eligibility to an individual practicing at that site. Before continuing with this application, please review the HPLRP Guidelines for detailed information regarding eligibility.

The HPLRP is administered without regard to race, color, religion, national origin, sex, gender, sexual orientation, age, or status as a handicapped individual or disabled veteran.

Section I: Applicant Profile *(This is the first of three sections that make up the DC HPLRP Application)*

Part A: Applicant Information, Education and Professional Experience

Name: _____ _____ _____
(First) (MI) (Last)

Provider Type: ○ Primary Care Physician ○ Psychiatrist ○ Dentist ○ Dental Hygienist

○ Nurse Practitioner ○ Nurse Midwife ○ Physician's Assistant ○ Registered Nurse

○ Licensed Clinical Social Worker ○ Clinical Psychologist ○ Professional Counselor

Personal Address: _____
(Number) (Street) (Apartment/Suite Number)

_____
(City) (State/Province) (Zip Code)

Home Phone: (____) _____ Work Phone: (____) _____

Email Address: _____

Date of Birth: _____ Race: ---------- Ethnicity: ----------

Are you a citizen ○ or permanent resident ○ of the United States?

Are you proficient in any language other than English? ○ Yes ○ No

If yes, please specify: _____

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Do you have a pending application with the National Health Service Corps (NHSC)? ◯ Yes ◯ No

Are you an AHEC Scholar? ◯ Yes ◯ No

List states in which you currently hold, or have held, a license to practice: _____

Have you ever been subject to any disciplinary action or licensure restrictions? ◯ Yes ◯ No

If yes, please attach a letter describing your circumstances.

Proposed practice site for HPLRP:

_____
(Site Name)

_____
(Number) (Street) (Suite Number)

_____
(City) (State) (Zip Code)

What date will you be available to begin practice as an active participant in the Health Professional Loan Repayment Program?

_____/_____/_____

MM DD YYYY

Are you interested in participating in the HPLRP for:

◯ 2 years ◯ 3 years ◯ 4 years

How did you learn about the DC Health Professional Loan Repayment Program (DC HPLRP)? *Check all that apply*

- ☐ HPLRP Advertisement
- ☐ HPLRP Website
- ☐ Other website: Please specify _____
- ☐ Friend/Colleague
- ☐ Job Fair: Please specify _____
- ☐ Employer
- ☐ School Sponsored Career Service: Please specify_____
- ☐ Other _____

Attachments

Include your health professional school transcripts and curriculum vitae showing your professional practice experience over the last five years. Your curriculum vitae should include information on practice locations, practice settings (solo, group, etc.); length of affiliation with each location, hospital affiliations and percentage of time spent providing direct patient services. Include copy of your signed contract or employment agreement with the employment site.

Include an attachment that describes your experiences with underserved populations and, if those experiences took place during the course of your residency or training program, describe the nature and length of the rotation(s). In the attachment, also describe your client profile for the last five years, including patients' age, insurance status, health status, etc. Include a copy of your DC license. Include verification of your personal information (driver's license, or state-issued id, or other supporting documentation as requested by DOH staff).

Submit Attachments

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Part B: Information Release and Attestation *(to be signed by applicant and designated HPLRP site contact)*

1. Information Release

I am applying for an educational loan repayment contract with the District of Columbia Health Professional Loan Repayment Program (HPLRP).

I consent to the release - to the District of Columbia Department of Health - private, sensitive, privileged, and otherwise confidential information about me to the extent that it bears upon any of the following: my education; internship, postgraduate, preceptorship, or residency specialty training; board certification; experience; professional conduct; ethics; ability to work with others; hospital and other affiliations; disciplinary actions; malpractice claims history; litigation experience; state licensure; and controlled substance licensure. I intend that this consent includes all information that reflects on my ability to safely, competently, and professionally perform the professional activities required of me should I receive a contract under this program. I agree that this consent extends to all persons, institutions, and entities that have such information about me including: colleges, universities, professional societies, hospitals, specialty boards, practice groups, clinics, insurance companies, partnerships, professional corporations, and employers, and to persons and committees associated with any of these. I also give my consent for all such persons, institutions, and entities to express their evaluation of me and make recommendations about my professional skill, conduct, and ability to perform clinical duties in the area for which I have applied.

I intend that a copy of this document may be relied upon as if it were the original.

Printed Name of Applicant: _____

Legal Signature of Applicant: _____ Date: _____

2. Application Attestation

I certify that the information I have provided in this application is accurate and complete to the best of my knowledge and belief. I understand my responses may be investigated and any willfully false representation is sufficient cause for rejection of this application.

Signature: _____ Date: _____

(Sign full legal name)

3. Site Attestation

As the designated site contact for HPLRP, I am aware of and support this application to the DC HPLRP.

Name: _____

Signature: _____ Date: _____

(Sign full legal name)

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Part C: Loan Information and Loan Repayment or Scholarship Service Commitments

Loans without appropriate documentation, loans paid in full, delinquent loans and loans from friends or relatives which are undocumented by a notarized contract at the time the loan is made do not qualify for repayment under this program.

Any person, who knowingly makes a false statement or misrepresentation in this loan repayment application, fraudulently obtains repayment for a loan, or commits any other illegal action in connection with this transaction is subject to a fine or imprisonment.

Total amount of health professional loans you are requesting to have repaid by the HPLRP:

$_____

Name of Lending Institution: _____

Complete Address: _____

_____

Telephone Number: (____) _____ Fax Number: (____) _____

Purpose of Loan:

_____

Type of Loan:

_____

Address where payments are sent (if different from above): _____

_____

Academic period covered by this loan:

From: _____ To: _____
(Month/year) (Month/year)

Loan Disbursement Dates (if known): _____

Do you have any existing service obligations? ○ Yes ○ No

If yes, name of program: _____

Address: _____

_____

Contact Person: _____

Telephone Number: (____) _____

Terms of obligation: _____

_____

Are you in default of this or any other obligation? ○ Yes ○ No

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If yes, please attach a letter describing your circumstances.

Part D. Applicant Certification

(Must be notarized)

I, _____, apply to enter into an agreement with the District of Columbia for repayment of all or part of my educational loans as described in this application. Repayment may be made only for educational expenses defined in the District of Columbia Health Professional Loan Repayment Guidelines and legislation and including school tuition and reasonable educational expenses defined as costs of education, exclusive of tuition, which are required by the school's degree program or an eligible program of study. Such expenses include fees for room, board, transportation and commuting costs, books, supplies, educational equipment and materials, or clinical travel, which were part of the estimated student budget of the school in which the participant was enrolled. I authorize the lender(s) named in Section I, Part C of my application to release information on my loan(s) to the administrator of the DC HPLRP.

_____
Applicant's Signature

On this_____ day of _____, 20_____,

_____ personally

appeared before me, _____, a Notary Public, and

signed this application, of which this Acknowledgment forms a part.

_____
Notary Public

My Commission Expires on_____

HPLRP Application Check List

Check each box below and return this checklist with the electronic portion (Section I) of your application:

Have you completed each of the following? If not, your application may be delayed or denied.

- **[]** Section I, Parts A, B and C and attachments (to be submitted electronically)
  - **[]** Applicant Profile (Section I of the HPLRP Application)
  - **[]** A copy of your health professional school transcripts and curriculum vitae
  - **[]** A copy of your current, unrestricted license to practice in the District of Columbia, as well as any residency completion and/or board certificates
  - **[]** A description of your experience with vulnerable populations including your client profile for the last five years (as described on page 2 of Section I of this application).
  - **[]** A copy of your signed contract or signed employment agreement with the employment site
  - **[]** Verification of personal information (a copy of driver's license, or state-issued id, or other supporting documentation as requested by DOH staff)
  - **[]** Signed and dated information release form
- **[]** Applicant Certification (Section I, Part D) (to be notarized and submitted in hard copy)
- **[]** Requests for three Recommendation Forms (Section II) to be mailed, faxed, or emailed to HPLRP@dc.gov (at least two recommendation forms must be from current/former supervisors)
- **[]** Request for Lender Certification (Section III) to be mailed, faxed, or emailed to HPLRP@dc.gov
- **[]** SECTION I, PART D Applicant Certification (Attach to application then submit electronically)

Please note: You are responsible for following up with your lender and professional recommendations to assure that the information is submitted to the Primary Care Bureau.