# Rhode Island Primary Care Educational Loan Repayment Program for Primary Care Nurse Practitioners and Physician Assistants
# 2018 Application

Application Deadline: Applications are accepted and award determinations will be made on a rolling basis.

**Mail completed application to:**
**Rhode Island Student Loan Authority, 935 Jefferson Blvd., Suite 3000, Warwick, RI 02886-2225**
**Attn: Primary Care Nurse Practitioner and Physician Assistant Loan Repayment Program**

**A. Applicant Information**

**○ Mr. ○ Ms. (circle one)**

Name: _____ Social Security Number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____ Cell Phone: _____

1. U.S. Citizen? ○ **Yes** ○ **No**
2. I am a: ○ Nurse Practitioner ○ Physician Assistant
3. Specialty (select one): ○ Family Practice ○ General Internal Medicine
   ○ General Pediatrics
4. Family Practice Only: Do you provide prenatal services? ○ Yes ○ No
   Delivery services? ○ Yes ○ No
5. Education: Name of School(s)/Program, Date and Degree Awarded:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

6. If Nurse Practitioner, have you been licensed: ○ YES ○ NO

License Number: _____ Date: _____

If Physician Assistant, have you been licensed? ○ YES ○ NO
License Number: _____ Date: _____

**B. Practice Information**

1. Name of Practice: _____

   Street Address: _____

   City: _____ State: _____ Zip Code: _____

2. Phone: _____ Days/Week: _____ Hours/Week: _____

3. Date employment began or will begin: _____

4. Practice Type (circle one): ○ **PUBLIC** ○ **PRIVATE, NON-PROFIT** ○ **PRIVATE, FOR PROFIT**

   Is this practice a Patient Centered Medical Home practice (NCQA, CSI-RI, BCBSRI, other:_____ ?) ○ **Yes** ○ **No**

5. Is this a salaried position? ○ **Yes** ○ **No**

6. Is there any sliding scale, including free care? ○ **Yes** ○ **No**

7. Is there any limit in the number of patients on Medicare/Medicaid cared for? ○ **Yes** ○ **No**

   a. If yes, please explain: _____

8. Estimate the current percent of Medicaid beneficiaries served by the practice:_____%.
   Is this based on numbers of **patients** or percent of **dollars** (circle one)?

9. Primary Service Area - Town(s): _____
   Other Practice Sites:

   a. Town_____ Days/Week _____ Hours/Week _____

   b. Town_____ Days/Week _____ Hours/Week _____

10. Will the applicant serve at other sites?

    If yes, name town(s):_____

11. Are you currently on staff at a hospital? ○ **Yes** ○ **No**

    If yes, what hospital?_____

12. Have you received an award from the Rhode Island Primary Care Education Loan Repayment Program in the past?

**Yes** **No** If yes, what year(s)?_____

13. Do you have an existing service obligation in return for a scholarship, loan forgiveness or loan repayment (such as National Health Service Corps, a University or other state)?

**Yes** **No**

a. If yes, Name of Program:_____
Address:_____
Contact Person:_____ Phone: _____
Terms of obligation: _____

b. Have you applied for federal loan repayment and been denied? If so, please provide details:
_____
_____

**C. Organization Recruiting:**

1. Name of Organization: _____

2. Contact Person:_____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Fax: _____ Email: _____

3. Specialty (select one): Family Practice General Internal Medicine

General Pediatrics

4. Will your practice/institution or another institution in the region offer a community match to enhance this award?

**Yes** **No**

If yes, name of organization providing match_____

If yes, indicate the fixed amount of the match _____, or is this a dollar-for-dollar match? _____

Will you provide other services and incentives to help ensure that this health care professional will remain in the Community?

**Yes** **No**

If yes, please describe:_____
_____

**D. Special Considerations.** Please describe any special or extenuating circumstances that should be considered in evaluating this application. This can include problems in recruiting, circumstances that make retention difficult, results of consumer surveys, input from physicians or other health care professionals, or issues you feel worthy of consideration. ***(Important: Information included in this section is very important for the selection committee that reviews applications – you may attach additional pages for this section.)***

***The Recruiter by signing below is confirming that the applicant has been offered a position and that the information in Section B and C of the application is accurate.***

Signature Recruiter: _____ Date: _____

Print Name: _____ Title: _____

**E. Required Statement of Need for Educational Loan Repayment Funds to Remain Practicing in Rhode Island**

Please attach a typed statement of why you have chosen to practice in the area of Rhode Island where you are located. Please include information on how the Educational Loan Repayment Program and other factors may influence your decision to remain in this area. ***Information included in this section is very important for the committee reviewing this application.***

***(ATTACH REQUIRED STATEMENT)***

Signature Applicant: _____ Date: _____

_____, _____
Print Name Print Title

**F. Outstanding Educational Loans:** List all outstanding student educational loans. Rhode Island Student Loan Authority must be able to verify these with lending/servicing institutions AS EDUCATIONAL LOANS. These must be ONLY YOUR STUDENT LOANS, and MAY NOT include any loans with another person, NOR MAY THEY INCLUDE mortgage, car, personal, business or any other type of loan except your own student educational loans.

**APPLICANT MUST COMPLETE NEXT TWO FORMS**

## Rhode Island Primary Care Educational Loan Repayment Program for Primary Care Providers
# RECIPIENT INFORMATION AND FINANCIAL DIRECTIVE

Name: _____ Social Security Number: _____

**This program complies with Section 108(f) of the Internal Revenue Code. This award is taxable income for recipient, reported on tax form 1099. Recipient is responsible for all tax payment and/or reporting of tax information to the IRS.**

| Student Loan Lender/Servicer: Name/Address/Phone | Date of Origin of Educational Loan | Loan ID Number | Original Amount of Education Loan (principal on origination date) | Current Loan Amount (principal+interest on this month's statement) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Attach additional pages, if necessary

Please complete and sign the enclosed ***Release of Information*** (Form #2). One form with your original signature must be returned for each Servicer/Lender listed above.

**Certification:**

I certify that the information given in this form and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in disqualification from participation in this program. I agree to provide grantor access to practice management data as required to verify compliance with grant requirements.

I give permission for Rhode Island Student Loan Authority to verify information contained in this application and acknowledge that this process may include discussing my application with lender(s) and/or employer(s) listed in this application.

If I have not yet secured employment at the time I submit my application, I give the Rhode Island Primary Care Educational Loan Repayment committee permission to share my contact information with eligible practices recruiting in my field.

It is my intent to remain in Rhode Island and in Primary Care for more than 4 years.

I certify that I understand eligibility requirements, the tax liability, and service commitment associated with the Rhode Island Education Loan Repayment award.

Signature: _____ Date: _____

*Applicant's Full Name*

# RELEASE OF INFORMATION

*(One form per servicer/lender)*

## Rhode Island Educational Loan Repayment Program for Primary Care Providers

**Part A:** (To be completed by recipient/student loan borrower)

Borrower Name: _____ Social Security Number: _____ ____ _____

Acct # _____ Date of Birth: _____ (month) _____ (day) _____ (year)

Name of Servicer/Lender: _____

Address: _____

Telephone number: _____ Web address: _____

RE: (Loan ID Number/estimated balance):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6._____

I, the above mentioned applicant/borrower, have been selected by the Rhode Island Educational Loan Repayment Program for Primary Care Providers to receive assistance with repayment of my educational loans. To facilitate this, please provide the information in regard to my account on the form below.

Thank you for your prompt attention to this request,

Signature: _____ Date: _____
*Applicant's Full Name*

**Part B:** (To be completed by lender)

Loan balance # 1: _____ Principal Balance: _____ Interest rate: _____ Fixed/Variable?

Loan balance # 2: _____ Principal Balance: _____ Interest rate: _____ Fixed/Variable?

Loan balance # 3: _____ Principal Balance: _____ Interest rate: _____ Fixed/Variable?

Loan balance # 4: _____ Principal Balance: _____ Interest rate: _____ Fixed/Variable?

Loan balance # 5: _____ Principal Balance: _____ Interest rate: _____ Fixed/Variable?

Signature: _____ Date: _____
*(Authorized Representative of Lending Institution)*

Institution's Federal EIN: _____

**Return to**: Rhode Island Student Loan Authority, 935 Jefferson Blvd., Suite 3000, Warwick, RI 02886-2225
attn: Primary Care Repayment Program. Fax: 401-468-2137