KORH
Kentucky Office of Rural Health

Kentucky State Loan Repayment Program

Provider Application

Demographic Information

First Name | Middle Initial | Last Name

Date of Birth | Social Security Number

Home Phone | Work Phone | E-mail

Current Street Address

City | State | Zip | County

Current Mailing Address (if different from above)

City | State | Zip | County

How did you hear about the Kentucky State Loan Repayment Program? (Check all that apply)

- ☐ Website
- ☐ Friend
- ☐ Publication
- ☐ Conference Exhibit
- ☐ Employer
- ☐ Other

This information is being collected for presenting data on race, ethnicity, and gender for Federal reporting purposes only.

Ethnicity:

- ◯ Hispanic/Latino
- ◯ Not-Hispanic/ Latino

Race:

- ☐ American Indian
- ☐ Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian
- ☐ Other Pacific Islander
- ☐ White

Gender

- ◯ Male
- ◯ Female

Professional Information

Type of Provider:

Name of Professional School Attended

Address

City | State | Zip

Date of Graduation

Residency Program (if applicable)

Address | City

State | Zip | Phone Number

Are you Board Certified?

◯ Yes
◯ No

Are you Board Eligible?

◯ Yes
◯ No

Name of Board

Date of Certification

License Information

Type

Date Issued

State

Expiration

License Number

Restriction

Has your license ever been restricted or revoked in any state?

◯ Yes ◯ No

If yes, please explain:

Do you have any professional disciplinary actions pending in any state?

◯ Yes ◯ No

If yes, please explain:

Eligibility Determination

Is this an application for a new 2-year commitment, or an extension to a prior commitment?

◯ New application, have not participated in the KSLRP previously.

◯ Extension to prior 2-year service commitment under the KSLRP.

Do you have an existing service obligation with any Federal, State, or other entity?
This means that as part of another program you are required to work/practice in a specific area or with a specific population for a specified amount of time. This may include university scholarships, grant programs, National Health Service Corps, and more.

◯ Yes ◯ No

If yes, please describe the obligation and when it will be completed.

Are you delinquent on any child support payments?

◯ Yes ◯ No

Are you in default or breach of contract for any student loans?

◯ Yes ◯ No

Have you defaulted on any Federal debt or have a judgement lien against you arising from a Federal debt?

◯ Yes ◯ No

If yes, please explain:

Professional Experience

Describe your Residency or Program training experience **outside the teaching hospital or professional school** as it pertains to your experience working with shortage area populations, rotations in rural and urban areas, and nature and length of rotations.

Professional References (3):

Name

Address

City

State

Zip

Phone

Name

Address

City

State

Zip

Phone

Name

Address

City

State

Zip

Phone

Practice Site

I have signed or will sign an agreement with the following practice site. (See *Practice Site Eligibility* on page 8 of the RFA for Practice Site eligibility)

Name of Site

County

Address

City

State

Zip

Name of Contact Person

Phone

Additional Scoring Criteria Information

Do you currently, or are you willing to begin, accepting students on rotation as a Preceptor or Clinical Supervisor?

- ◯ *Yes, I currently accept students.*
- ◯ *Yes, I would like to begin taking students.*
- ◯ *No, I cannot take students due to the low number of providers in the community.*
- ◯ *No, I do not wish to begin taking students.*

What is your motivation for working in a rural area? Include any ties you have with the community, what drew you to wanting to practice in a rural area, and what your long term career goals are.

I understand that, if approved for a loan repayment, I must fulfill the following obligations:

- Practice (work full-time) in a Health Professional Shortage Area (HPSA) determined by the health care organization co-sponsoring the loan repayment for the duration of the loan repayment obligation;

- Will not, in the case of a patient seeking care, discriminate on the basis of the individual's ability to pay for care or on the basis that payment for care will be made pursuant to the programs established in Title XVIII or Title XIX of the Social Security Act;

- Accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under Part B of Title XVIII of such Act, and will enter into an appropriate agreement with the state agency that administers the state plan for medical assistance under Title XIX of such Act to provide services to individuals entitled to medical assistance under the plan; and,

- The recipient will provide to the Kentucky State Loan Repayment Program a copy of his/her annual license certification renewal form and will report semi-annually by letter the name, location and nature of practice to the community organization(s). The report will include a copy of the agreement with the recipient under Title XVIII of the Social Security Act in which the recipient agrees to accept assignment of patients served under Title XVIII.

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the Kentucky State Office of Rural Health to contact references and program directors listed in the application for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification, and willfully providing false information will result in disqualification from participation in this program.

Printed Name

Date

Signature