



Kentucky Office of Rural Health

Kentucky State Loan Repayment Program Provider Application (Extension)

PERSONAL INFORMATION			
First Name	Last Name	Middle Initial	
Home Address			
City	State	Zip Code	County
Mailing Address (If different from above)			
City	State	Zip Code	County
Home Phone		Work Phone	
E-mail Address			
Date of Birth		Social Security Number	
How did you find out about the Kentucky State Loan Repayment Program? (Check all that apply)		<input type="checkbox"/> College/University Faculty and Staff <input type="checkbox"/> Conference Exhibit <input type="checkbox"/> Employer <input type="checkbox"/> Friend/Colleague <input type="checkbox"/> Kentucky Office of Rural Health Website <input type="checkbox"/> Kentucky Office of Rural Health Weekly Update <input type="checkbox"/> Online Search <input type="checkbox"/> Other: _____	
<i>The following demographic information is being collected strictly for federal reporting purposes:</i>			
Gender		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Ethnicity		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Race			
<input type="checkbox"/> American Indian or Alaska Native		<input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander	
<input type="checkbox"/> Asian		<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> White	

PROFESSIONAL INFORMATION

Provider Type

<input type="checkbox"/> Doctor of Allopathic Medicine (MD)	<input type="checkbox"/> Licensed Clinical Social Worker (LCSW)
<input type="checkbox"/> Doctor of Osteopathic Medicine (DO)	<input type="checkbox"/> Licensed Professional Clinical Counselor (LPCC)
<input type="checkbox"/> Physician Assistant (PA)	<input type="checkbox"/> Health Service Psychologist (HSP)
<input type="checkbox"/> Nurse Practitioner (NP)	<input type="checkbox"/> Marriage and Family Therapist (MFT)
<input type="checkbox"/> Certified Nurse-Midwife (CNM)	<input type="checkbox"/> Psychiatric Nurse Specialist (PNS)
<input type="checkbox"/> Registered Nurse (RN)	<input type="checkbox"/> Alcohol and Substance Abuse Counselor
<input type="checkbox"/> Dentist (DDS, DMD)	<input type="checkbox"/> Pharmacist (RPh, PharmD)
<input type="checkbox"/> Registered Dental Hygienist (RDH)	

Specialty (If applicable)

Name of Professional School Attended

Professional School Address

City

State

Zip Code

Country

Date of Graduation

Name of Residency Program (If applicable)

Residency Program Address

City

State

Zip Code

Country

Date of Completion

Are you board certified?

Yes

No

Are your board eligible?

Yes

No

NPI#

Name of Board

Date of Certification

License Type

Date Issued

State Where License Issued

License Expiration Date

License Number	Restriction
<p>Has your license ever been restricted or revoked in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, please explain:</i></p>	
<p>Do you have any professional disciplinary actions pending in any state? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>If yes, please explain:</i></p>	

PRACTICE SITE			
<p>I <input type="checkbox"/> have signed <input type="checkbox"/> will sign <i>an agreement to work at the following practice site:</i></p>			
Name of Practice Site			
Practice Site Address			
City	State	County	Zip Code
Name of Practice Site Contact		Phone Number for Practice Site Contact	
E-mail Address for Practice Site Contact			
Name of Parent Organization (If applicable)			
Parent Organization Address			
City	State	County	Zip Code
<p>Are you willing to accept students on rotation as a Preceptor or Clinical Supervisor, if permitted and applicable? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>			

PROFESSIONAL REFERENCES

Please provide the contact information for three (3) professional references — people who are familiar with and can speak about your abilities in the health care industry.

Name

Mailing Address

City

State

Zip Code

Phone Number

E-mail Address

Relationship to Applicant

Name

Mailing Address

City

State

Zip Code

Phone Number

E-mail Address

Relationship to Applicant

Name

Mailing Address

City

State

Zip Code

Phone Number

E-mail Address

Relationship to Applicant

AFFIRMATION OF ELIGIBILITY CRITERIA

Please initial next to each statement indicating your confirmation that you meet each of the following Kentucky State Loan Repayment Program (KSLRP) eligibility criteria:

I am a U.S. citizen (either U.S. born or naturalized) or U.S. National.	<input type="checkbox"/>
I have a current, full, permanent, unencumbered, unrestricted professional license, certificate, or registration in Kentucky in the discipline in which I am applying to serve.	<input type="checkbox"/>
I am employed at an eligible KSLRP site, or have accepted an offer of employment at an eligible site where service will begin (and I will begin seeing patients) no later than January 15, 2019.	<input type="checkbox"/>
I agree to practice full time, as defined by a minimum of 40 hours per week for a minimum of 45 weeks per year, providing primary health services at an eligible site.	<input type="checkbox"/>
I agree to use KSLRP funds only to repay qualifying loans.	<input type="checkbox"/>
I have no existing service obligation — nor will I incur any service obligation — that would be performed concurrently with, or overlap with, my KSLRP service obligation.	<input type="checkbox"/>
I am not in default on any federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, federal income tax liabilities, Federal Housing Authority loans, etc.) or any non-federal payment obligations (e.g., court-ordered child support payments or state tax liabilities), even if the applicant is currently considered to be in good standing by that creditor.	<input type="checkbox"/>
I have not had any federal or non-federal debt written off as uncollectible or received a waiver of any federal service or payment obligation.	<input type="checkbox"/>
I have not breached a prior service obligation to the federal government, a state or local government, or other entity, even if the applicant subsequently satisfied that obligation through service, monetary payment, or other means.	<input type="checkbox"/>
I have no judgment liens arising from federal debt.	<input type="checkbox"/>
I am not currently excluded, debarred, suspended, or disqualified by a federal agency.	<input type="checkbox"/>

ESSAY QUESTION

Respond to the following prompt in 300-500 words:

Describe the care you have provided to underserved rural and/or urban populations at your current practice site during your participation in the Kentucky State Loan Repayment Program. Please provide concrete examples. How does your continued employment at this site (and in a Health Professional Shortage Area) figure into your long-term career goals?

PROGRAM OBLIGATIONS

I understand that, if approved to participate in the Kentucky State Loan Repayment Program, 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 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. I understand that signing this document does not establish a contractual agreement between myself and the Kentucky State Loan Repayment Program.

Printed Name

Date

Signature