DC Department of Health
PRIMARY CARE BUREAU
Health Professional Loan Repayment Program
899 North Capitol Street, NE 3rd Floor
Washington, DC 20002
(202) 442-9168 EMAIL: HPLRP@dc.gov

SITE CERTIFICATION APPLICATION

This application must be completed by those practices interested in employing a health professional who receives or would like to receive loan repayment from the DC Health Professional Loan Repayment Program (HPLRP). A separate Site Certification Application must be submitted for each site where applicants may provide services.

PLEASE NOTE: *Sites that are not located in Health Professional Shortage Area (HPSA) or Medically Underserved Areas (MUA) that correspond to the types of services the sites provide are not eligible to be HPLRP Service Obligation Sites. For detailed information regarding Service Obligation Site eligibility, please see the HPLRP Program Guidelines and/or Title 22B, Chapter 61 of the DC Municipal Regulations. For-profit practices are not eligible for the HPLRP.*

1. Name of Organization/Practice: _____

2. Site address to be certified:

_____
Number Street Suite#

_____ ----------
Zip Code Ward

3. Contact Person: _____Title: _____

4. Phone: _____ Ext._____ Fax_____ Email: _____

5. This site is a (please check all that apply):
FQHC___ FQHC Look-Alike___ Recipient of DC Capital Expansion Funds___ Non–Profit___

DC DOH/DMH/DCPS/DOC Program (please specify)_____

Other (please specify) _____

6. Types of services provided at site (please check all that apply):

Primary Care ___ Mental Health ___ Dental ___

7. Is this site located in a health professional shortage area (HPSA) that relates to the services the site provides?

Yes _____ If yes, HPSA ID _____ No _____

8. Is this site located in a medically underserved area (MUA)?

Yes ____ If yes, MUA ID _____ No _____

9. Number of full time equivalent providers on site by specialty:

Family Practice____ Pediatrics____ Internal Medicine____ OB/GYN____ Dental____ Mental Health____

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10. Number of full time equivalent providers on site by provider type:

Physician ____ Physician Assistant____ Nurse Midwife____ Nurse Practitioner____

Dentist ____ Dental Hygienist ____

Licensed Clinical Social Worker ____ Clinical Psychologist ____ Professional Counselor____

11. Name and credentials of health professional(s) applying for this program N/A ☐

_____

12. Number of current J-1 visa waiver physicians at this site: _____

13. Number of current National Health Service Corps (NHSC) providers at this site: _____

14. Does the practice offer a sliding scale fee* based on income or ability to pay?
Yes ____ (Please submit a copy) No ____

***PLEASE NOTE:** Sliding Scale Fee is a formal, posted up-front discount policy based on income or ability to pay and is tied to the Federal Poverty Levels (see: http://aspe.hhs.gov/POVERTY/). Bad debt write-offs are not included.*

15. Please list the number of unduplicated patients served by the practice site for the most recent 12-month period for which complete data are available:

Please specify: 12-month time period: _____ / _____ to _____ / _____
MM YYYY MM YYYY

	Number	Percentage
Medicaid	_____	_____
Alliance	_____	_____
Medicare	_____	_____
Commercial Insurance	_____	_____
Self-Pay/Sliding Fee	_____	_____
Other (Please specify: _____)	_____	_____
Total	0 _____	_____

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16. Compliance with Service Obligation Site Requirements **(for Executive Director/CEO initials)**

The site agrees to comply with the following HPLRP program requirements:

_____a. Designate an individual to serve as a program point of contact at the site who can sign all invoices and service verification forms that must be submitted by the site's HPLRP providers;

_____b. Provide the site's annual patient data, by payer class;

_____c. Provide annual patient data, by payer class, for any current HPLRP providers;

_____d. Provide HPLRP providers with salaries and benefits that are comparable to other non-program providers at the organization (salaries must not be adjusted to account for loan repayment amounts);

_____e. Notify the Primary Care Bureau of any change in site or HPLRP provider employment status;

_____ f. Submit a Site Certification Renewal application prior to October 1 of each year if there is an active HPLRP provider at the site.

17. Assurances of Service Obligation Site Eligibility **(for Executive Director/CEO initials)**

This site is eligible to be a certified service obligation site (SOS) in that it:

_____ a. Provides primary care, mental health or dental services as part of a public or non-profit practice;

_____ b. Accepts Medicare, Medicaid and DC Alliance;

_____ c. Charges for services at the usual and customary rates prevailing in the discipline, except that the SOS has a policy providing that patients unable to pay the usual and customary rates shall be charged a reduced rate according to the site's sliding scale fee policy based on federal poverty level guidelines;

***PLEASE NOTE:** Sliding Scale Fee is a formal, posted up-front discount policy based on income or ability to pay and is tied to the Federal Poverty Levels (see: http://aspe.hhs.gov/POVERTY/). Bad debt write-offs are not included.*

_____d. Does not discriminate on the basis of a patient's ability to pay for care or the payment source;

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_____e. Is located in a federally designated Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) that corresponds to the services the site provides;

_____f. Can provide employment contracts for all HPLRP providers that cover the period of loan repayment applied for by each participant, and has the financial means to support the provider, including salary, benefits, and malpractice insurance expenses for a minimum of 24 months; and

_____g. Can assure that HPLRP providers work full-time (minimum of 40 hours) in their professions at the site.

Please include a separate sheet for any additional comments.

THE FOLLOWING ITEMS MUST BE ATTACHED IN ORDER TO PROCESS YOUR APPLICATION: Attachments

1. Background information about the practice;
2. A copy of the site's brochure or marketing material;
3. A copy of your Sliding Scale Fee policy and application and a copy of the public notice at the practice site that indicates a sliding scale fee are in effect.

I hereby certify that, to the best of my knowledge, the information contained in this application is accurate, and I hereby authorize the DC Department of Health's Primary Care Bureau to verify all information presented.

Signature: _____ Date: _____

Title: _____

EMAIL OR MAIL TO:
DC Department of Health
Primary Care Bureau
899 North Capitol Street NE, 3rd Floor
Washington, DC 20002
Telephone: (202) 442-9168 Email: HPLRP@dc.gov

Save As Submit Form

For Official Use Only:

Application Received: _____ Reviewed by: _____ Reviewer's Signature:_____

Approved Denied Bureau Chief's Signature _____ Date: _____