DC | HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

DC HEALTH PROFESSIONAL LOAN REPAYMENT 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 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 be issued in April and June/July.

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 Office homepage of the DC Department of Health's Website and detailed in this application. 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 general primary, dental, or mental medical healthcare services that correspond to the Health Professional Shortage Area (HPSA) or Medically Underserved Area/Population (MUA/MUP) in which the practice site is located or Specialist or Subspecialists (practicing in their specialty) must work to serve residents of a Medically Underserved Area/Population (MUA/P) in Wards 7 or 8 and accept a minimum percentage of indigent care equivalent to 45% *and must accept/offer Medicare, Medicaid, Alliance health care coverage, or similar public insurance programs at a threshold determined by the Department of Health and or DC Health Director. 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.*

HPLRP Certified Service Obligation Sites listing may be obtained by contacting our office or by referencing the link on our website at the following URL: https://dchealth.dc.gov/service/dc-health-professional-loan-repayment-program-hplrp

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)

Gender:_____;

Q1: What sex were you assigned at birth, on your original birth certificate?
1. Female ☐
2. Male ☐
(Don't know) ☐
(Prefer not to answer) ☐

Q2: What is your current gender? [Mark only one]
1. Female ☐
2. Male ☐
3. Transgender ☐
4. [If respondent is American Indian or Alaska Native] Two-Spirit ☐
5. [Free-text option] I use a different term: ☐

Applicant's Name: _____

(Don't know) ☐
(Prefer not to answer) ☐

NPI Number:_____

Home Address:_____

City:_____State:_____ZipCode:_____

Date of Birth: _____; **Telephone** #: _____; **DC License** #: _____

Provider Type*: ____Primary Medical Care; _____Allopathic Physician; _____Osteopathic Physician.*

_____Advanced Practice Nurse/Nurse Practitioner; _____Physician Assistant; _____Registered Nurse; _____Certified Nurse Midwife; _____Licensed Clinical Social Worker; ____Psychiatric Nurse Specialist; _____Clinical Psychologist; _____Health Service Psychologist; _____Licensed Professional Counselor; _____Dentist; _____Pediatric Dentist; _____Registered Dental Hygienist; _____Psychiatrist; _____*Other.*

If you are a Primary Care Specialist, please select your specialty, as appropriate: _____Adult; _____Family Practice; _____Family Practice-Geriatrics; _____Family Practice with OB; _____General Practice; _____Geriatrics; _____Internal Medicine; _____Internal Medicine – Geriatrics; _____OB/GYN (Obstetrics and Gynecology):_____Pediatrics; _____Psychiatry; _____Psychiatry- Geriatrics;_____Psychiatry-Neurology

If you are a specialist or sub-specialist and practice in your trained specialty in Ward 7 or 8, please select as appropriate: _____Cardiology; ____ Endocrinology; _____ Infectious Diseases; _____ Nephrology; _____ Neurology; _____Oncology; _____Ophthalmology; _____ Podiatry; _____ Pulmonary Diseases.

Race & Ethnicity:

_____Hispanic/Latino Origin (Ethnicity); _____Non-Hispanic or Latino Origin; _____American Indian/Alaskan Native; _____ Asian; _____Black or African American; _____White; _____Native Hawaiian or Other Pacific Islander.

Language(s) Spoken (Other than English):

____Spanish; _____ Chinese;_____ Vietnamese; _____ Korean; _____ Amharic; _____Cantonese; _____French; ____German; _____Russian; _____Tagalog; _____Other if yes, what language?_____

Note terms are from HRSA Bureau of Health Workforce - https://bhw.hrsa.gov/glossary

Are you from a Rural Residential Background? _____Yes/No
Link to definition

Are you from a Disadvantaged Background? _____Yes/No
Link to definition

Are you or were you a Veteran? ____Active-Duty Military; _____Not A Veteran; _____ National Guard; _____Reservist; _____Veteran – Prior Service; _____Veteran-Retired.

Applicant's Name: _____

Prior HRSA/BHW Award Recipient: ____Yes/No - if yes, what type: _____
Link to definition

Do you provide services for SUD/MAT/MOUD/OTP?Yes/No; if yes, select your patient panel size: _____DW 30; _____DW 100; _____DW 275; _____None of the above;

Do you provide Medication Assisted Treatment (MAT) Services? _____Yes, Buprenorphine; _____Methadone; _____Buprenorphine plus counseling; _____Naltrexone; _____None of the Above?

Do you hold a Substance Use Disorder License or Certificate? _____Yes/No?

Do you provide any and or all of the following select services, as follows?

_____COVID-19 Treatment or Prevention; _____Integrated Behavioral Health in Primary Care Services; _____Substance Use Treatment Services; _____Telehealth; _____None.

Are you Board Certified (or the equivalent) in your field of practice? (If yes, please specify certifying body, and certification type): _____.

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List all medical schools attended, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary.		
School #1 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
Street Address: _____; **City: _____State: _____ Zip Code: _____;**		**Country (If not the United States):**
School #2 Name:	**Graduation Date:**	**Degree/Certificate Awarded:**
Street Address: _____; **City: _____State: _____ Zip Code: _____;**		**Country (If not the United States):**

List all residency programs, in reverse chronological order, beginning with the most recent at the top. Transcripts should be provided from the issuing institution for each school that you attended and listed below. Use additional sheets if necessary. Attach Residency Certificate copies.	
1st Residency Program Name:	
Street Address: _____; **City: _____; State: _____;** **Zip Code: _____.**	**Dates in Attendance:** **From: ___/___/____ To: ___/____/____**
2nd Residency Program Name:	
Street Address: _____; **City: _____; State: _____;** **Zip Code: _____.**	**Dates in Attendance:** **From: ___/___/____ To: ___/____/____**
3rd Residency Program Name:	

Applicant's Name: _____

Street Address: _____; **City: _____; State: _____;** **Zip Code: _____.**	**Dates in Attendance:** **From: ___/___/____ To: ___/____/____**
Do you have a pending application with the National Health Service Corps (NHSC)? Yes: _____; No: _____.	
Are you an AHEC Scholar? Yes:____; No: ____;	
Lists 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 or use the space below:**	

Contact our office to request a site list or visit our website: [DC Health Professional Loan Repayment Program - HPLRP | doh]

(1) Proposed practice site for HPLRP – List percent time there_____.

(Site Name)

(Street Number) (Street Name) (Suite Number)

(City) (State) (Zip Code)

(2) Proposed practice site for HPLRP – List percent time there_____.

(Site Name)

(Street Number) (Street Name) (Suite Number)

(City) (State) (Zip Code)

(3) Proposed practice site for HPLRP – List percent time there_____.

(Site Name)

(Street Number) (Street Name) (Suite Number)

(City) (State) (Zip Code)

Applicant's Name: _____

Note: Loans for which you incurred a service obligation that you will not fulfill before the submission deadline of the NHSC LRP, S2S LRP application or any other loan repayment program hinder you ineligible (meaning, you cannot be in two loan-repayment programs at once). Applicants who willingly sign up for two contracts simultaneously will be disqualified from future eligibility and are subject to financial penalties.

All Other (List type)

Are you interested in participating in the HPLRP for (please select one): ☐ 2 yrs; ☐ 3 yrs; ☐ 4 yrs.

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*
_____ *Other*

Attachments

- Include your 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 all of your college/training transcripts (unofficial copy is fine but school's name must be listed on the document)
- Include a 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 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 current DC health professional license and board certificates.
- All college and or medical school transcripts (unofficial copies if school is identified are appropriate).
- Include verification of your personal information **(driver's license, or state-issued ID, or other supporting documentation as requested by DC Health staff)**.

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: _____
(Sign full legal name)

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 (officially designated site contract representative)

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)

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 all 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 _____

Obligation Terms: _____

Are you in default of this or any other obligation? Yes: ☐ No: ☐ ;

If yes please attach a letter describing your circumstances.

Part D. Applicant Certification

(Must be notarized and the notarized copy mailed, hand-delivered or sent by courier – no electronic submission for this form)

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 (can't count as "other related costs" too), 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 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 DC Health staff)
- **[]** Signed and dated information release form (Form B)
- **[] Transcripts from all schools must be attached (unofficial copies are O.K.)**

[] Section I, Part D- Applicant Certification (to be notarized and submitted in hard copy) – initial copy can be electronic but hard copy original must follow.

[] Requests for three Recommendation Forms (Section II) to be mailed, faxed, or emailed to HPLRP@dc.gov directly from the recommenders (at least two recommendation forms must be from current/former supervisors and one from a professional associate.)

[] Request for Lender Certification (Section III) to be mailed, faxed, or emailed to HPLRP@dc.gov directly from the lender (initial electronic copies can be submitted but hard copy lender data will be required within 3 weeks of application deadline).

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 Office and please verify with your lender if they require a release form from you to provide HPLRP with the requested information.

"Save File" and "Attach" to Email for Electronic Submission: Send to HPLRP@dc.gov

DC Health

Health Care Access Bureau

Primary Care Office
Health Professional Loan Repayment Program
DC Health
2201 Shannon Place SE
5th Floor
Washington, DC 20020
P: (202) 442-5892; F: (202) 442-4948 E-MAIL: HPLRP@dc.gov