

NEBRASKA LOAN REPAYMENT PROGRAM

Application Instructions for Rural Health Professional

*The following health professionals are eligible to apply for the Nebraska Loan Repayment Program: **Physician***, **Physician Assistant***, **Nurse Practitioner***, **Dentist****, **Psychologist**, **Licensed Mental Health Practitioner**, **Pharmacist**, **Physical Therapist**, and **Occupational Therapist**.*

**These health professionals must specialize in family practice, general internal medicine, general pediatrics, general surgery, obstetrics/gynecology, or psychiatry.*

***Dentists must specialize in general dentistry, pediatric dentistry, or oral surgery.*

NOTE: State of Nebraska employees are not eligible for the Nebraska Loan Repayment Program.

The Nebraska Loan Repayment Program, by statute, requires a 3-year practice obligation to the State of Nebraska in a state-designated shortage area and requires the health professional to accept Medicaid patients. Current shortage area listings and maps are on the Office of Rural Health website at <http://www.dhhs.ne.gov/orh/>.

Instructions

1. Make sure that the community where you want to practice is in a state-designated shortage area and that a local entity (such as a hospital, clinic, foundation, or employer) is willing and able to provide the required matching funds. The local entity must complete an Application for Community Participation.

Definitions:

State-designated shortage areas are defined by the Rural Health Advisory Commission and based on statutory and Commission-defined guidelines.

Full-time, as defined in statute, means 40 hours per week. If the health professional practices in the shortage area less than 40 hours per week, benefits will be reduced. The health professional must work a minimum of 20 hours per week in the shortage area to be eligible for loan repayment.

Qualified educational debts means government and commercial loans obtained by students for postsecondary education tuition, other educational expenses, and reasonable living expenses. You must attach documentation *from the lender(s)* of your current educational debt balance(s).

2. The health professional cannot be self-monitored. *The Nebraska Loan Repayment Program requires community participation. Individual health professionals cannot be the “community” participant in order to fund their own loan repayment.*

3. **Only completed applications will be accepted.** A completed application consists of a community participation application, a health professional application, and documentation *from the lender(s)*, of student loans. Documentation of student loans printed off the Internet must include the recipient's name, current loan balance, and contact information of the lender. Once submitted the application is for the community and health professional and cannot be transferred.
4. Complete the Application for Health Professional, sign and date the application, attach documentation of student loans *from the lender(s)*, and return the application to the address below. **Incomplete applications will not be accepted.**
5. If the application is approved by the Rural Health Advisory Commission, a loan repayment contract will be signed by the Department of Health and Human Services, the local entity, and the health professional. Some of the obligations of the local entity under the loan repayment contract require the local entity to:
 - Provide annual matching funds in the amount of up to \$20,000 per year for three years;
 - Provide verification to the Office of Rural Health every three months of the health professional's practice during the period of obligation; and
 - If requested by the Office of Rural Health, provide a copy of the employment agreement, if any, between the health professional and the local entity.

Upon verification of quarterly practice in the shortage area, the Office of Rural Health will pay the loan repayment recipient directly. The loan repayment recipient is always responsible for paying his or her educational loans. As of January 1, 2009, funds awarded under the Nebraska Loan Repayment Program are no longer included in adjusted gross income for tax purposes (P.L. 111-148, 3/23/10).

6. Please address all correspondence concerning the Nebraska Loan Repayment Program to:

**Nebraska Department of Health and Human Services
Office of Rural Health
P.O. Box 95026
Lincoln, NE 68509-5026**

7. For additional information, please call the Office of Rural Health at (402) 471-2337.

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APPLICATION FOR HEALTH PROFESSIONAL page 1 of 4

FOR OFFICE USE ONLY community match _____ shortage area _____
loan documentation _____ FTE _____ eligible for _____
NE Lic _____ Attestation Form _____

Please type or print clearly.

1. Name _____
(Last) (First) (M.I.) (Maiden)

2. Home Address _____
E-mail _____

3. Phone (home/cell) (____) _____ WORK (____) _____

4. Birth Date (mm/year) _____ Soc. Sec. # _____ (required for state benefits)

5. Profession (circle one): MD/DO DDS/DMD Psychologist PA NP LMHP Pharmacist OT PT

6. Specialty (check one):

A. To be completed by MD/DO, PA, and NP: ___ Family Practice ___ General Internal Medicine
___ General Pediatrics ___ Obstetrics/Gynecology ___ General Surgery ___ Psychiatry

B. To be completed by DDS/DMD: ___ General Dentistry ___ Pediatric Dentistry ___ Oral Surgery

7. If you are a physician, have you completed a residency? ___ Yes ___ No

If Yes, date completed _____ If No, expected completion date _____

Name and Location (city, state) of residency program _____

What is your residency specialty? _____

Do you plan to provide prenatal care and deliveries? ___ Yes ___ No

8. Education:

Undergraduate Education
Name of School

Attended Degree Year
From Mo/Yr To Mo/Yr Received Received

Graduate Education
Name of School

Attended Degree Year
From Mo/Yr To Mo/Yr Received Received

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9. Have you received loan repayment through another source? Yes No

If Yes, please describe source and amount received _____

10. Are you, or will you be, receiving loan repayment from another source other than the local match?

Yes No If Yes, please describe source and amount _____

11. List the primary facility where you intend to practice:

Name of Practice _____

Address _____

_____ Phone (_____) _____

Contact Person _____
(Name) (Title)

County/Countries of Practice _____

12. Please identify the agency responsible for the local match, if different than the practice site.

Local Agency _____

Address _____

_____ Phone (_____) _____

Contact Person _____
(Name) (Title)

13. When do you plan to begin, or did you begin, your shortage area practice? Date _____
(Month/Day/Year)

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14. Educational Loan Information

Attach documentation from the lender of your current loan balances. List the name and current balance of each student loan you plan to repay under the Nebraska Loan Repayment Program. Documentation of student loan balances printed off the Internet must include the recipient's name, current loan balance, and contact information of the lender. If your application is approved, the amount of repayment you receive will be based on your current loan balances at the time you begin your practice obligation. Please type or print legibly. If additional space is needed, make a copy of this form or add another page.

<u>Loan Number or Description</u>	<u>Lender</u>	<u>Current Balance</u>
1. _____	_____	\$ _____
2. _____	_____	\$ _____
3. _____	_____	\$ _____
4. _____	_____	\$ _____
5. _____	_____	\$ _____

TOTAL: \$ _____

CERTIFICATION BY APPLICANT

I hereby certify to the accuracy of the above information and make application to enter into an agreement with the State of Nebraska for repayment of all or the appropriate portion of qualified educational loan(s) incurred solely for the costs of health professional education, including reasonable living expenses. I hereby authorize the government or financial institution to release the information about the loan listed above to the Nebraska Loan Repayment Program.

Warning: 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 and/or imprisonment.

I have read this statement and understand its contents.

Signature of Applicant _____ **Date** _____

Print Name _____

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APPLICATION FOR HEALTH PROFESSIONAL page 4 of 4

United States Citizenship Attestation Form

For the purpose of complying with Neb Rev. Stat. §§ 4-108 through 4-114, I attest as follows:

I am a citizen of the United States.

-OR-

I am a qualified alien under the federal Immigration and Nationality Act, my immigration status and alien number are as follows: _____
And I agree to provide a copy of my USCIS documentation upon request.

I hereby attest that my response and the information provided on this form and any related application for public benefits are true, complete, and accurate and I understand that this information may be used to verify my lawful presence in the United States.

PRINT NAME _____

(first, middle, last)

SIGNATURE _____

DATE _____

NEBRASKA LOAN REPAYMENT PROGRAM
Application Instructions for Local Agency Participation

The following health professionals are eligible to apply for the Nebraska Loan Repayment Program: *Physician**, *Physician Assistant**, *Dentist***, *Psychologist*, *Nurse Practitioner**, *Pharmacist*, *Licensed Mental Health Practitioner*, *Physical Therapist*, *Occupational Therapist*

**These health professionals must specialize in family practice, general internal medicine, general pediatrics, general surgery, obstetrics/gynecology, or psychiatry.*

***Dentists must specialize in general dentistry, pediatric dentistry, or oral surgery.*

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2. ***The Nebraska Loan Repayment Program requires community participation. Individual health professionals cannot be the “community” participant in order to fund their own loan repayment.***
3. The application process consists of a community participation application and a health professional application. Once submitted the application is for the community and health professional and cannot be transferred.
4. The local entity needs to complete both sides of the community participation application. A separate page may be added to answer the questions on the back of the application form.
5. Sign and date the application. ***Incomplete applications will not be accepted.***

6. If the application is approved by the Rural Health Advisory Commission, a loan repayment contract will be signed by the Department of Health and Human Services, the local entity, and the health professional. Some of the obligations of the local entity under the loan repayment contract require the local entity to:
 - Provide annual matching funds in the amount of up to \$20,000 per year for three years;
 - Provide a suitable practice location for the health professional in the shortage area;
 - Provide verification to the Office of Rural Health every three months of the health professional's practice during the period of obligation; and
 - Upon request of the Office of Rural Health, provide a copy of the employment agreement, if any, between the health professional and the local agency.
7. As of January 1, 2009, funds (both state and local match) awarded under the Nebraska Loan Repayment Program are no longer included in adjusted gross income for tax purposes (P.L. 111-148, 3/23/10).
8. Please address all correspondence concerning the Nebraska Loan Repayment Program to:

**Nebraska Department of Health and Human Services
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P.O. Box 95026
Lincoln, NE 68509-5026**

9. For additional information, please call the Office of Rural Health at (402) 471-2337.

NEBRASKA LOAN REPAYMENT PROGRAM

APPLICATION FOR COMMUNITY PARTICIPATION

Please identify the local agency responsible for the local match.

Local Agency Name _____ Phone Number (____) _____

Address _____
Street City State ZIP

Name of Authorized Representative _____
Name Title

Please identify the primary facility where the health professional will practice

Name of Facility _____ Phone Number (____) _____

Address _____
Street City State ZIP

County/Countries (town) of Practice _____
Please include County (Town) of satellite or network sites, if applicable.

Contact Person _____
Name Title Phone Number E-Mail Address

Name of Health Professional Applying for Loan Repayment: _____

Practice Start Date in Shortage Area: (mm/dd/yyyy) _____

Type of Health Professional (check one)

- | | |
|---|---|
| <input type="checkbox"/> Physicians | <input type="checkbox"/> Pharmacists |
| <input type="checkbox"/> Physician Assistants | <input type="checkbox"/> Licensed Mental Health Practitioners |
| <input type="checkbox"/> Nurse Practitioners | <input type="checkbox"/> Occupational Therapists |
| <input type="checkbox"/> Dentists | <input type="checkbox"/> Physical Therapists |
| <input type="checkbox"/> Psychologists | |

Medical Specialty

(to be completed for **physician, physician assistant, or nurse practitioner**) (check one)

- | | |
|--|--|
| <input type="checkbox"/> Family Practice | <input type="checkbox"/> General Internal Medicine |
| <input type="checkbox"/> General Surgery | <input type="checkbox"/> General Pediatrics |
| <input type="checkbox"/> Obstetrics/Gynecology | <input type="checkbox"/> Psychiatry |

Dental Specialty (to be completed for **dentist**) (check one)

- | | |
|--|--|
| <input type="checkbox"/> General Dentist | <input type="checkbox"/> Pediatric Dentist |
| <input type="checkbox"/> Oral Surgeon | |

1. Describe the practice opportunity for the practitioner who would be recruited/retained through the Loan Repayment Program. Would he/she practice full-time in a single location, or split time between two or more sites? _____
How often would he/she be on call? _____
Would he/she be self-employed or salaried? _____
If salaried, by whom? _____

We ask that you complete the demographic data which are collected for reporting purposes only, but you are not required to provide this information.

NEBRASKA LOAN REPAYMENT PROGRAM
Demographic Questionnaire

Gender

Male Female

Age

20 and under	41-50
21-30	51-60
31-40	61 and over

Ethnicity

Hispanic NonHispanic

Race

White

Black/African American

American Indian or Alaskan Native

Asian/Pacific Islander

Other

State of current residence _____