Health Care Workforce Financial Assistance Program Application

The Health Care Workforce Financial Assistance Program is administered without regard to race, color, religion, national origin, sex, age or status as a handicapped individual or disabled veteran.

You must obtain or be eligible to obtain an unrestricted license to practice in Utah.

Section I

Personal Information

Name:

Profession:

Specialty(ies):

Are you a Geriatric health provider?

☐ Yes ☐ No

Address:

Phone Number:

Type:

E-mail:

Last Four Digits of SSN:

Place of Birth:

Are you a citizen or permanent resident of the United States?

☐ Yes ☐ No

Are you fluent in any language other than English?

☐ Yes ☐ No

If Yes, please specify:

Describe in one page or less, your personal and cultural experiences with underserved populations.

Section II Education

Undergraduate Education

Name of institution:

Address of institution:

Start date: Graduation date:

Degree(s) obtained:

Professional Education

Name of institution where you received your professional degree:

Address of institution:

Start date: Graduation date:

Degree(s) obtained:

Post graduate Training

Name of institution where you completed any postgraduate training:

Affiliated with what university or program:

Name of program director:

Address:

Start date: End date:

Education Continued

Are you:

Board Certified? Board Eligible?

Year certified:

Describe any additional training experience outside of formal education. Include experiences working with under-served populations including the nature and length.

Section III Professional Experience

Outline your professional practice experience over the last 5 years; specifically the location(s), description of setting(s), and length of affiliation.

Describe your professional practice for the last five years,specifically information on age mix, under-served populations, percent of Medicaid patients, and uninsured patients (if known):

Employment history: Provide the name and contact information for the last two sites where you have practiced since completing your professional training.

A.

Site name:

Contact name:

Title of contact person:

Site address:

Phone number:

Hours per week:

Start date:

End date:

B.

Site name:

Contact name:

Title of contact person:

Site address:

Phone number: Hours per week:

Start date: End date:

List states in which you currently hold, or have held a professional license; note which ones are active.

Have you ever been subject to any disciplinary action or license restrictions?

☐ Yes ☐ No

If yes, by whom (please explain):

Section IV Professional References

Applicant agrees that the Department can contact any professional references regarding this application. A minimum of three (3) references are required.

1.

Name: Position/Title:

Working relationship: Phone:

Address:

2.

Name: Position/Title:

Working relationship: Phone:

Address:

3.

Name: Position/Title:

Working relationship: Phone:

Address:

Section V Personal References

Please give the names and addresses of three (3) persons, not related to you by blood or marriage, who are qualified to give information regarding your character and/or financial need. A minimum of three (3) references are required.

1.

Name: Relationship to applicant:

Address:

Phone:

2.

Name: Relationship to applicant:

Address:

Phone:

Personal references continued

3.

Name: Relationship to applicant:

Address:

Phone:

Section VI Loan Repayment or Scholarship Service Commitments

Do you have any existing service obligations

☐ Yes ☐ No

If Yes, name of program:

Address:

Contract entity:

Phone:

Terms of obligation:

Are you in default of this or any other obligation?

☐ Yes ☐ No

If Yes, describe circumstances:

When will you be available to begin or when did you start practicing under the Health Care Workforce Financial Assistance Program at the desired site?

Month

Year

Section VII Practice Preferences

1a.

If applicable, please describe preference of practice location in Utah in terms of: type of practice (solo, group, etc.), maximum distance from a hospital, size of community, preferred area in Utah, types of services available in community, climate, geographic features, recreational outlets, etc.
NOTE: If you already have an offer of employment with a designated Utah practice location, Please state name of site location, name of contact person, and nature of your offer.

1b. Please include information on the practice preference location in Utah in which you are applying for financial assistance:

Name of Practice Location:

Name of Direct Supervisor: Title:

Address:

Phone:

1c. Please include information on the allocation of time at the practice preference location in which you are applying for financial assistance:

1c1. Is the position in which you are requesting full-time?

☐ Yes ☐ No

If Yes, skip to 1c3. If no, answer 1c2.

1c2. If No, please provide the number of hours per week and your full-time equivalency (FTE) status at the practice preference site.

Hours per week:

FTE, as determined by the site:

1c3. Please provide your allocation of time (hours per week) at the practice preference location (numbers should total 100% of your FTE):

Administration: ☐ Clinical/ Practice based: ☐ Hospital Based ☐

Teaching: ☐ Other (specify): ☐

1c4. Please provide your anticipated start date at the site you are requesting:

☐

Please note that awards may be prorated or funded based on clinical care hours.

2. List the most important factors to you when selecting a practice location:

1. ☐
2. ☐
3. ☐
4. ☐

3. Describe the characteristics you possess that would make you a good candidate to receive loan repayment for an underserved population practice:

4. If chosen for this program, are you willing to provide care to Medicaid and indigent patients?

- [ ] Yes
- [ ] No

5. Please list any other competencies or awards not referred to in this application.

Please include a copy of your curriculum vitae and Utah Professional license along with this application.

CERTIFICATION

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 _____

RELEASE OF INFORMATION

I am applying for educational loan repayment through the Health Care Workforce Financial Assistance Program.

I consent to the release to the Utah 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, post-graduate, preceptorship, or residency specialty training, board certification; experience; professional conduct; ethics; ability to work with others; hopsital and other affiliations; disciplinary actions; malpractice claims history; litigation experience; state licensure; and controlled substance licensure. I intend that this consent include all information that reflects on my ability to safely, competently, and professionally perform the professional activities required of me should I receive a grant under this program.

I agree that this consent extend 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, condcut, 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.

Signature of applicant:

Printed name of applicant:

Date:

Last four of SSN:

Section VIII Loan Information

1. Complete Section A. Return this section to 3760 S. Highland Drive Salt Lake City Utah, 84114

2. Complete and send Section B. to your lender or have your lender send a copy of the loan information directly to the address above indicating the total unpaid principal balance and for each loan, the disbursement date and type of loan.

3. An application cannot be processed until Section B, the information from the lender(s) is received by the Department.

4. You are responsible for following up with your lender to assure that the above information is sent.

5. If your educational loans have been sold to another lender, or consolidated by a loan marketing association, submit the request for loan information to that lender, not the original lender

6. To assure that Section A and Section B can be matched upon receipt, please write the academic period covered by the loan in the upper right corner of Section B.

7. If you have multiple lenders, please make additional copies of sections A and B for each lender.

Section A.

Name of lending institution:

Address:

Phone:

Fax:

Purpose of loan:

Type of loan:

Address where payments are sent:

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 fine or imprisonment.

Section VIII **Loan Information Continued**

Amount of this loan you are requesting to have repaid by this program:

Academic period covered by this loan:

From: To:

Loan Disbursement Dates

NOTE: *Loans without appropriate documentation, loans paid in full, delinquent loans, and loans from friends or relatives which are undocumented by a contract notarized at the time of the making of the loan, DO NOT qualify for repayment under this program.*

Certification by Applicant
(must be notarized)

I apply to enter into an agreement with the State of Utah for repayment of all or part of my educational loans submitted with this application. Repayment may be made only for educational expenses defined in the Health Care Workforce Financial Assistance Program rule as tuition, fees, books, supplies, educational equipment and materials, and reasonable living expenses. I authorize the lender(s) named above to release information on my loan(s) to the administrator of the Health Care Workforce Financial Assistance Program.

State of Utah)
SS)
County of _____)

On this_____day of _____, 20_____,

_____ personally appears before me,

_____, a notary public, and signed this application of which this acknowledgement forms a part.

_____
Notary Public

_____
Residing at

My commission expires on _____.

Section B. Loan Data and Certification

To be completed by the lender

Applicant's Social Security Number: _____

_____ is applying for a grant to repay educational loans through the State of Utah's Health Care Workforce Financial Assistance Program. Please provide the program with the information requested below.

1. Original amount of loan: $_____

2. Current balance: $_____ Date of balance: _____

Interest rate: _____% Simple interest? YES NO

If other than simple, please explain: _____

_____

Disbursement Date		Type of Loan (Eg.Subsidized Stafford)		Amount for Each Loan That You Service	
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$
Date		Type		Amount	$

Is any loan or loans listed above in default? YES NO

Section B. Cont'd

Lender's Certification

The undersigned states that, to the best of his/her knowledge, the loan(s) identified in this section is a bona fide, legally-enforceable loan(s) made for the purpose of meeting the borrower's cost of attending a school or institution where they obtained their professional education.

Name of lending institution:_____

Complete address:_____

_____

Phone number: __(____)_____

Name/Title of officer:_____

Signature: _____ Date:_____

Return Section B to:
Office of Primary Care and Rural Health
3760 S Highland Drive
Salt Lake City, Utah 84114
or;
opcrh@utah.gov

CHECK LIST

Have you completed and included all of the following? If not, your application may be delayed or denied.

Have all sections of the grant application been completed? Sections "Not Applicable" should have been marked N/A. All sections MUST be filled out.

Submit a completed application for education loan repayment to the Utah Department of Health, Office of Primary Care and Rural Health including:

1. Personal information
2. Loan certification

A copy of your curriculum vitae must be included in your application.

Be a licensed professional who has a license in good standing to practice in Utah. You must provide a copy of your current, unrestricted license to practice in Utah.

Be available to begin service at an eligible employment site within one month of entering into a contract with the Department.

Provide the Utah Department of Health with documented evidence of employment. A copy of your signed contract or signed employment agreement with the employment site must be provided.

The information release form in this application must be signed and dated.

PLEASE NOTE: You are responsible to follow up with your lender to assure that the information is sent.

Submit all documentation together. Incomplete applications will be returned. When all materials have been submitted, funding priority will then be assigned.