DELAWARE
STATE LOAN REPAYMENT PROGRAM

SPECIAL AWARD
FOR PEDIATRIC DENTIST(S) IN SOUTHERN KENT AND/OR SUSSEX COUNTIES, DELAWARE

PROGRAM GUIDANCE AND APPLICATION

A PROGRAM ADMINISTERED BY

DELAWARE HEALTH CARE COMMISSION
DELAWARE INSTITUTE FOR DENTAL EDUCATION AND RESEARCH (DIDER)

IN COLLABORATION WITH

DELAWARE DIVISION OF PUBLIC HEALTH AND
DELAWARE HIGHER EDUCATION OFFICE

SEPTEMBER 2011

Contents

Program Description

The purpose of this *special* Delaware State Loan Repayment award is to increase the number of pediatric dentists in designated underserved areas in Southern Kent and/or Sussex Counties within the State of Delaware.

This award, of up to $100,000.00, is not subject to the same guidelines and requirements of the standard Delaware or Federal State Loan Repayment Program parameters. The successful applicant(s) of this award will agree that pediatric dental services will be provided at a site in Southern Kent (as defined by the Delaware Health Care Commission) and/or Sussex Counties for a minimum of 2 years. Receipt of this award will not reduce the eligibility of the applicant to apply for funds from the standard Delaware State Loan Repayment Program.

Applicants for this *special* award must have outstanding qualifying higher education loans and/or capital/equipment expenditures to establish a pediatric dental practice in Southern Kent or Sussex Counties, which must not be in default.

Requirements

<u>Dental Professional</u>

Applicants must meet the following conditions:

- Be one of the following:
    - A Delaware licensed dentist who is either Board Eligible or Board Certified by the American Academy of Pediatric Dentists and limits his practice to pediatric dentistry and is either a sole proprietor or an employee of a dental practice that is limited to the practice of pediatric dentistry with the exception of a Federally Qualified Health Center or the Division of Public Health.
    - A dental corporation or partnership where the owners are Delaware licensed dentists who are either Board Eligible or Board Certified by the American Academy of Pediatric Dentists and limits the practice to pediatric dentistry.
    - A Federally Qualified Health Center to establish or continue the provision of pediatric dental services by a Board Certified or Board Eligible pediatric dentist who is Delaware licensed.

All practicing dentists who are either employees or owners of the applicant must meet the following requirements:

- Be a Board Certified or Board Eligible pediatric dentist whose practice is limited to pediatric dentistry.
- Be a citizen or legal permanent resident of the United States or be a selected refugee approved by the U.S. Attorney General.
- Have a valid license to practice dentistry in the State of Delaware by contract signature date.
- Must not have been convicted of any felony, including but not limited to violent felonies, as so defined under either Federal or State law and as more

particularly defined and enumerated in 11 Del. C. Sec. 4201; and not have been convicted or found guilty of, or disciplined by this or any other State licensing Board or Agency authorized to issue a certificate to practice dentistry in this or any other State, for unprofessional conduct as so defined in 24 Del. C. Sec. 1731(a);

Practice Site

The practice site must meet the following conditions:

- Be located in Southern Kent (as defined by the Delaware Health Care Commission) or Sussex County, Delaware
- The practice site must provide services full-time (37.50 hours) for a minimum obligation of 2 years from the date of award.
- Must agree that a minimum of 30% of their scheduled appointments will be comprised of Medicaid and S-CHIP (Delaware Healthy Children Program) patients and/or low-income (<200 FPL) dentally uninsured patients who will be provided care at reduced rates (established by the DIDER Board) or free-of-charge. Low-income patients may include participants in the Nemours Dental Outreach program and the Vocational Rehabilitation program administered through the Delaware Division of Public Health. Unannounced audits of office scheduling records may be made periodically by Loan Repayment officials.

Applications

Applications for this special award will be accepted on an on-going basis until August 15, 2012 and a final determination will be made by August 31, 2012.

The applications may flow through three levels of consideration for approval: 1.) State Loan Repayment Review Committee; 2.) Delaware Institute for Dental Education and Research (DIDER), and 3.) Delaware Health Care Commission for final decision. The Delaware Health Care Commission Reserves the right to approve or decline any application.

The award recipient must enter into a contract with the State of Delaware, committing to comply with all program requirements, including but not limited to the following:

- Provision of pediatric dental services
- Ownership of a practice limited to pediatric dental services in Southern Kent or Sussex County, Delaware
- Notify the Delaware Health Care Commission in writing within 30 days of any contractual changes that result in termination of contract or change in practice scope, and

- Report all changes in writing to:

Delaware Health Care Commission
Loan Repayment Coordinator
Margaret O'Neill Building, Third Floor
410 Federal Street, Suite 7
Dover, Delaware 19901

Phone: (302) 739-2730
Fax: (302) 739-6927

Applications must include:

- Appendix A
  Application Form for Special Award for Pediatric Dentist(s)

- Appendix B
  Delaware Loan Information and Verification Form
  Original Appendix C must be signed by applicant in blue ink, notarized and submitted with application

- Appendix C
  Reporting Form for Pediatric Dentist(s) at Practice Site (if other than Applicant)

- Appendix D
  Special Pediatric Dental Award
  Practice Site Information Form

- Appendix E
  Special Pediatric Dental Award Quarterly Report
  (This quarterly reporting process will update the Delaware Health Care Commission with regard to progress on delivery of services and adherence to Award requirements

- Acknowledgement of Contract Default Provision Clause

Applications for this special award will be accepted on an on-going basis until the close of business on August 15, 2012. The final determination will be made by August 31, 2012.

This deadline is binding and, as such, no exceptions will be made. Untimely applications will not be considered.

Submit applications to:

Delaware Health Care Commission
Pediatric Dental Award
Margaret O'Neill Building, Third Floor
410 Federal Street, Suite 7
Dover, Delaware 19901

Phone: (302) 739-2730
Fax: (302) 739-6927
Website: http://dhss.delaware.gov/dhss/dhcc/slrp.html

APPENDIX A
STATE OF DELAWARE
SPECIAL PEDIATRIC DENTAL AWARD
APPLICATION FORM

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1. Full Name: (Please Print) _____ Date of Application: _____

2. Date of Birth: _____ Place of Birth: _____

3. US Citizen: ☐ Yes OR ☐ No

4. Present Home Address: _____

_____

_____

5. Home Telephone: ( ) _____ Cell Phone: ( ) _____
Business Telephone: ( ) _____ E-Mail: _____

6. Name of Practice Site, if applicable _____

Address: _____

Note: If practice is owned by pediatric dentist(s) who employ other pediatric dentist(s) who will be practicing at the awarded facility must complete a separate form for each pediatric dentist. (see Appendix B)

7. License Type: _____

State: _____ Number: _____

Date Issued: _____ Expiration Date: _____

The applicant must submit a query to the National Practitioner Data Bank and provide the Delaware Health Care Commission with that report.

Has your license ever been suspended or revoked? * ☐ Yes ☐ No

Are any professional disciplinary actions pending? * ☐ Yes ☐ No

Have you ever been convicted of or pled guilty to a felony as so defined under either Federal or State law and as more particularly enumerated in 11 Del. C. Sec. 4201? *

☐ Yes ☐ No

*If you answered yes to either of the above questions, please attach an explanation to this application.

Are You Board Eligible? ☐ Yes ☐ No

Are You Board Certified? ☐ Yes ☐ No

Date of Certification: _____

Name of Board: _____

Sub-Specialty Board: _____

8. Education (Please use additional paper as necessary)

College/Program: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Graduate School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Dental School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Residency Program:

Please list the information for the residency program most recently completed. If you have completed several residencies, or if your postgraduate training was completed through several programs, attach the required information for these programs to the application.

Residency: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Please indicate if your education, employment or licensure records are under another name(s):

_____ _____

Name Name

9. Program Eligibility (Please use additional paper if needed):

Do you have an existing service obligation due to any educational loans received?

☐ Yes ☐ No

If yes, please provide the following information.

Program Name: _____

Address: _____

_____

Contact Person: _____

Telephone: ( ) _____

When will this obligation be complete? _____

Do you have a current legal obligation to pay child support? ☐ Yes ☐ No

If yes, please provide the following information:

Name of child: _____

Name and address of person/agency payment is mailed to: _____

Telephone number of person/agency payment is mailed to: ( ) _____

When will this obligation be complete? _____

10. Describe your education and practice experience, which you believe qualifies you to participate in the Special Pediatric Dental Award. Attach a one or two page description to this application that specifically includes the following:

- Training and experience and commitment to providing services to underserved and vulnerable populations;
- Practice experience in shortage areas;
- Personal origins or other factors that describe your commitment to practice in a shortage area and/or to serve vulnerable populations;
- Service awards received during your education or practice;
- Pre-professional experiences which caused you to decide to practice in a shortage area; and
- Dentist should discuss collaborative practice experience and commitment to working with dental hygienists and other practitioner disciplines.

Selecting a practice opportunity is a very important decision. The following questions, along with those above, are designed to assist in making compatible matches between applicants and applicant practice sites and the patient population.

11. Language(s) Spoken Fluently

☐ English
☐ Spanish
☐ Arabic
☐ Indian
☐ French
☐ German
☐ Chinese
☐ Other (please specify) _____

12. Race/Ethnicity (collected for workforce research purposes only)

☐ Black, not of Hispanic origin
☐ Hispanic
☐ White
☐ Asian
☐ American Indian , Alaskan Native
☐ Pacific Islander, Native Hawaiian
☐ Other (please specify) _____

13. Geographical Area(s) or Origin

Are you a native of a rural or urban underserved area, or have you spent a significant amount of time living or working in such an area?

☐ Yes (If yes, please elaborate.)
☐ No

14. Geographical Area(s) of Interest

Rate the area(s) of Delaware in which you would consider working with one (1) being your first choice and three (3) being your last.

_____ Southern Kent County
_____ Sussex – Eastern (Coastal/Resort area)
_____ Sussex – Western

Rate the areas in which you would consider working with one (1) being your first choice and two (2) being your last.

_____ Suburban
_____ Rural

15. Other Considerations/Comments:
Please discuss any preferences and/or requirements that you or your family members have regarding such factors as proximity to recreation, special interests or social activities, availability of other work/training opportunities (i.e. for your spouse/significant other); proximity to schools, etc. Use additional paper if necessary.

16. How did you hear about the Special Pediatric Dental Award?

17. Certification:
I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I hereby authorize DHCC to contact references and program directors listed in the application for the purposes of obtaining information about my professional qualifications, experience, abilities, and criminal history background. I understand that information I have provided is subject to verification.

Signature of Special
Pediatric Dental Award Applicant

Date

APPENDIX B

DELAWARE LOAN INFORMATION AND VERIFICATION FORM

The following information must be provided for *each* loan that you are applying to have repaid under the Delaware Loan Repayment Program. **APPLICANTS**: Please complete PART A and then submit PART B to your lenders directly for verification. The Delaware State Loan Repayment Program *is not* responsible for submitting PART B to your lender.

PART A – TO BE COMPLETED BY APPLICANT

Name of Lending Institution and/or Federal, State or Other Government Program:

_____

_____	_____	_____	_____
Street	City	State	Zip Code

Date of Loan: _____ Account Number: _____

Original Amount of Loan: $_____ Number of Payments Made: _____

Current Balance: $_____ Date of Balance: _____

Payment Amount: $_____ Interest Rate: Compounded or Simple: _____

Purpose of Loan (as indicated on loan application): _____

_____

Any loan eligible for Federal loan consolidation is eligible for repayment if obtained for the purpose of meeting the borrower's direct costs of attending undergraduate or graduate school, a school of medicine, or a school or osteopathy. Direct education costs include tuition, fees, books and supplies, living expenses, and other items normally associated with the cost of attendance for one academic year as defined by the U.S. Department of Education's Student Aid Handbook. Loans not eligible for Federal loan consolidation will be considered if documentation is presented that establishes the proceeds from the loans were used to meet direct education costs. Credit card debt and funds received from the Delaware Institute for Medical Education and Research (DIMER) are ineligible for repayment. The Delaware Loan Repayment Program will only pay toward the educational costs associated with one health professional degree, and a determination will be made of the proportion of a consolidation loan that will be paid for successful applicants.

Copy of Loan Agreement Attached:	☐ Yes	☐ No
Copy of Loan Application(s) Attached:	☐ Yes	☐ No
Copy of Appropriate Consolidated Loan Documents Attached:	☐ Yes	☐ No

Dear Lender(s): (Retain a copy of this form as record of advanced payment request)

I am requesting that your institution submit the information requested as soon as possible to:

Loan Repayment Coordinator
Delaware Health Care Commission,
Margaret O'Neil Building, Third Floor,
410 Federal Street, Suite 7,
Dover, DE 19901

Phone: (302) 739-2730, or
Fax: (302) 739-6927

_____
Printed Name of Loan Applicant

CERTIFICATION:
I hereby certify to the accuracy of the above information and apply to enter into an agreement with the Delaware Loan Repayment Program for repayment of educational loans, incurred solely for the costs of education at an undergraduate or graduate school, a school of medicine, or a school of osteopathy (for tuition, educational expenses or living expenses from a college, university, government or commercial source). I hereby authorize the financial institution or Government named in item 1 above to release this information about the loan listed in item 1 above to the administrator of the Delaware Loan Repayment Program.

Warning: any person who knowingly makes a false statement or misrepresentation in this loan repayment transaction, bribes or attempts to bribe a Federal or state official, fraudulently obtains repayment for a loan under this agreement or commits any other illegal action in connection with this transaction may be subject to a fine or imprisonment under Federal statute. I have read this statement and understand its contents.

_____ _____
Signature of Loan Repayment Applicant (use **blue** ink) Date

_____
Printed Name of Loan Repayment Applicant

PART B – APPLICANT SHOUD SUBMIT TO LENDER FOR VERIFICATION

The individual identified on this form has applied to participate in a State of Delaware Loan Repayment Program. The Delaware Loan Repayment Program is a program designed to improve the recruitment and retention of health care providers in underserved areas of Delaware. The individual identified above states that, to the best of his or her knowledge, the loan information provided is a bona fide legally enforceable commercial, Federal, state, or other government educational loan obtained for the purpose of meeting the borrower's costs of attending undergraduate or graduate school, a school of medicine, or a school of osteopathy (for tuition, educational expenses or living expenses from a college, university, government or commercial source) or capital loan expenditure. Please verify the information according to your records and indicate any corrections in the "comment" space provided below. Also, please indicate your title and date this form in the spaces provided.

COMMENTS:

_____

_____

_____

I hereby certify to the accuracy of the loan information contained on this Loan Information and Verification Form, or as corrected by my notations or comments:

Signature: _____ Title: _____ Date: _____

Lending Institution
Representative

Address: _____ Telephone: _____

_____

_____

E-Mail Address: _____

State of Delaware
Delaware Health Care Commission
Delaware Institute for Dental Education and Research
Delaware Higher Education Commission

Request to Release
Personally Identifiable and Confidential Information

The Family Educational Rights and Privacy Act (FERPA) allows institutions of higher education, state education agencies, and other agencies administering student aid programs to release detailed information to only the student. The student may; however, voluntarily waive their privacy rights to the person(s) they choose to authorize in the statement below. By completing this form the named person(s) will have the ability to obtain information regarding the student's financial aid and/or student loan files.

I, _____ , hereby waive my rights under the Family Educational Rights and Privacy Act (FERPA) by authorizing the Delaware Health Care Commission and Delaware Higher Education Commission, acting as agents for the Delaware Institute for Medical Education and Research to receive any requested information concerning my financial aid application, or application(s) for student loans, and other "non-directory" information pertinent to my application for the Delaware State Loan Repayment Program for Health Care Providers. The institutions and agencies directed to release information to the State's agents are listed below:

Health Professions Educational Institutions:

1. _____

_____

_____

Lenders/Guaranty Agencies/Loan Servicers:

1. _____
2. _____
3. _____

_____
Student's Signature
(use **blue** ink)

_____
Printed Name of Student

Notary Seal

_____
Social Security Number

_____
Date

APPENDIX C
STATE OF DELAWARE
SPECIAL PEDIATRIC DENTAL AWARD
PEDIATRIC DENTIST(S) AT PRACTICE SITE
(if other than applicant, complete for each dentist)

1. Full Name: (Please Print) _____ Date of Application: _____

2. Date of Birth: _____ Place of Birth: _____

3. US Citizen: ☐ Yes OR ☐ No

4. Present Home Address: _____

_____

_____

5. Home Telephone: ( ) _____ Cell Phone: ( ) _____

Business Telephone: ( ) _____ E-Mail: _____

6. Name of Practice Site, if applicable _____

Address: _____

7. License Type: _____

State: _____ Number: _____

Date Issued: _____ Expiration Date: _____

Has dentist's license ever been suspended or revoked? * ☐ Yes ☐ No

Are any professional disciplinary actions pending? * ☐ Yes ☐ No

Has dentist ever been convicted of or pled guilty to a felony as so defined under either Federal or State law and as more particularly enumerated in 11 Del. C. Sec. 4201? *

☐ Yes ☐ No

*If you answered yes to either of the above questions, please attach an explanation to this application.

Is dentist Board Eligible? ☐ Yes ☐ No

Is dentist Board Certified? ☐ Yes ☐ No

Date of Certification: _____

Name of Board: _____

Sub-Specialty Board: _____

8. Education (Please use additional paper as necessary)

College/Program: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: (____) _____

Graduate School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: (____) _____

Dental School: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: (____) _____

Residency Program:

Please list the information for the residency program most recently completed. If you have completed several residencies, or if your postgraduate training was completed through several programs, attach the required information for these programs to the application.

Residency: _____

Address: _____

_____

From: _____ To: _____

Degree/Diploma: _____ Discipline: _____

Contact Person: _____

Telephone: ( ) _____

Please indicate if education, employment or licensure records of pediatric dentist(s) at award site are under another name(s):

_____ _____

Name Name

9. Language(s) Spoken Fluently

☐ English ☐ French
☐ Spanish ☐ German
☐ Arabic ☐ Chinese
☐ Indian ☐ Other (please specify) _____

10. Certification:
I certify that the information provided is accurate and complete to the best of my knowledge. I hereby authorize the Delaware Health Care Commission to contact references and program directors listed in the application for the purposes of obtaining information about professional qualifications, experience, abilities, and criminal history background. I understand that information I have provided is subject to verification.

_____ _____

Signature of Special Pediatric Dental Award Recipient — Date

APPENDIX D

Special Award for Pediatric Dentist

PRACTICE SITE INFORMATION FORM

---

1. Practice Site: _____

Street Address: _____

City: _____ State: DE Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

2. Contact: _____

Street Address: _____

City: _____ State: DE Zip: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Cell: _____

AREA OF PRACTICE	STAFFING LEVEL		PROJECTED HIRING TIMELINE (Please include estimated date if known)			
	Full	Current	1-3 Months	4-6 Months	7-12 Months	More than 12 Months
Pediatric Dentists						
Dental Hygienist						
Dental Assistant						
Other (Please Specify)						

3. Signature of Applicant _____

Date: _____

APPENDIX E

Special Award for Pediatric Dentist

PRACTICE SITE QUARTERLY REPORT

REPORTING PERIOD _____ ***to*** _____

1. Practice Site: _____

Street Address: _____

City: _____ State: DE Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

2. Contact: _____

Street Address: _____

City: _____ State: DE Zip: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Cell: _____

3. Practice Site Data Regarding Active Clients

Total number of patients receiving pediatric dental care during previous quarter _____

Total number of patients during previous calendar quarter below 200% of Federal Poverty Level _____

Please provide information on the percent of the total patient population of the practice that falls under the following payment categories:

AGE GROUP	MEDICAID or S-CHIP	SELF-PAY (UNINSURED) NEGOTIATED/ REDUCED FEE or FREE SERVICE	COMMERCIAL INSURANCE	TOTAL
Birth– 11 Years	%	%	%	%
12 - 18 Years	%	%	%	%
Total	%	%	%	%

4. Staffing Levels

AREA OF PRACTICE	STAFFING LEVEL		PROJECTED HIRING TIMELINE (Please include estimated date if known)			
	Full	**Current**	**1-3 Months**	**4-6 Months**	**7-12 Months**	**More than 12 Months**
Pediatric Dentists						
Dental Hygienist						
Dental Assistant						
Other (Please Specify)						

5. Practice Site Hours of Operation

DAY	TIME (Start and End)		TOTAL HOURS
Monday	AM:	PM:	
Tuesday	AM:	PM:	
Wednesday	AM:	PM:	
Thursday	AM:	PM:	
Friday	AM:	PM:	
Saturday	AM:	PM:	
Sunday	AM:	PM:	

PRACTICE SITE AGREEMENT

The Delaware Health Care Commission (DHCC) is committed to ensuring that all Delaware residents have access to quality, affordable health care. The director or applicant official for the facility or practice site applying for the Special Pediatric Dentist Award Repayment Program must initial each of the following requirements:

ACCESS

_____ The practice site agrees to comply with all of the Program requirements set forth in this Agreement and guidelines.

_____ The awarded applicant will provide health care services for at least forty (40) hours a week at the practice site named in the application for a minimum of two (2) years, as agreed upon in the contract.

_____ At least 32 of the minimum 40 hours per week will be spent providing clinical services practice site named in the application, during normally scheduled office hours. The remaining hours will be spent providing inpatient care to patients of the approved site, and/or in practice-related administrative activities.

_____ The practice site agrees to provide health services to Medicaid and S-CHIP, and uninsured patients on a reduced or pro bono basis for those patients demonstrating a hardship.

_____ The practice site has a nondiscrimination policy that prohibits discrimination based on race, creed, disability or religion.

ACCESS (continued from page E-2)

_____ The practice site must allow all dentists to agree that a minimum of 20% of their scheduled appointments will be comprised of Medicaid patients and/or low-income (<200 FPL) dentally uninsured patients who will be provided care at reduced rates or free-of-charge.

_____ I understand and acknowledge that the review of this practice site application is discretionary and that in the event a decision is made not to approve the site application, I hold harmless the State of Delaware, DHCC and any and all State employees and/or any and all individuals or organizations involved in the review process from any action or lack of action made in connection with this request.

COMPREHENSIVE SYSTEM OF CARE

_____ The providers shall practice in ambulatory settings that assure the availability of services, including after hours coverage, and arrangements for inpatient coverage and referrals, as needed.

QUALITY OF CARE

_____ The practice site has a credentialing program in place to review references and verify licensure and certification status of all providers, including National Practitioner Data Bank Query.

_____ The practice site has a quality monitoring and improvement system in place, which may include patient satisfaction surveys, peer review systems, clinical outcome measures or other such tools.

_____ Services will be delivered in a culturally appropriate fashion so as to be sensitive and responsive to the needs of the target population.

_____ The practice site will address retention of providers through monitoring turnover rates, clinical team management efforts, pay comparability, surveys, exit interviews, and other means.

_____ The practice site agrees to cooperate with mail, telephone and/or site visits conducted by DHCC for the purpose of monitoring compliance with the terms of this award.

I certify that the information provided in this quarterly report true and correct. I also understand that any intentional or negligent misrepresentation(s) of the information contained in this application may result in the forfeiture of eligibility to participate in this program.

Signature of Award Recipient: _____

Title: _____ Date: _____

Special Award for Pediatric Dentist in Southern Kent and/or Sussex Counties, Delaware
Default Provision in Award Contracts

IMPORTANT NOTE:

This award is made possible through a Federal Grant to the State of Delaware. All loan repayment awards made utilizing any Federal funds are subject to the provisions of the default clause indicated below and are irrevocable in the event of breach of contract. Please read carefully and initial below.

The default provision below is included in the executed contract between the successful candidate(s) and the State of Delaware/Delaware Health Care Commission. Please read carefully.

DEFAULT PROVISION: Should the participant breach this written contract by failing to complete the specified service commitment the participant will owe the State of Delaware an amount equal to the sum of the following:

a. The total of the amount paid by Special Pediatric Dental Award to, or on behalf of, the participant for loan repayments for any period of obligated service not served;

b. An amount equal to the number of months of obligated service delivery not completed multiplied by $7,500.00; and

c. Interest on the amounts above at the maximum legal prevailing rate, as determined by the Treasurer of the United States, from the date of breach, except that the amount the State of Delaware is entitled to recover shall not be less than $31,000.00

By my signature below, I certify that I have read and fully understand the implications should I breach this written contract by failing to complete the specified service commitment

Signature of Award Recipient: _____

Date: _____