DELAWARE LOAN REPAYMENT PROGRAM FOR HEALTH PROFESSIONALS

PROGRAM MANUAL and APPLICATIONS

A Program Administered by

DELAWARE HEALTH CARE COMMISSION
DELAWARE INSTITUTE FOR MEDICAL EDUCATION AND RESEARCH
DELAWARE INSTITUTE FOR DENTAL EDUCATION AND RESEARCH

In collaboration with

DELAWARE DIVISION OF PUBLIC HEALTH &
DELAWARE HIGHER EDUCATION OFFICE

Updated November 2012
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Program Description

- The Delaware Loan Repayment Program is designed to recruit health professionals to areas of the State that have been identified as underserved by the Delaware Health Care Commission. Applications are currently being accepted for these specialties:

<table>
<thead>
<tr>
<th>Advanced-degree Practitioners</th>
<th>Mid-level Practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physicians (MD and DO)</td>
<td>Registered Clinical Dental Hygienists</td>
</tr>
<tr>
<td>• Family Medicine*</td>
<td>Primary Care Certified Nurse Practitioners</td>
</tr>
<tr>
<td>• Osteopathic Practitioners*</td>
<td>Certified Nurse Midwives</td>
</tr>
<tr>
<td>• Internal Medicine*</td>
<td>Primary Care Physicians Assistants</td>
</tr>
<tr>
<td>• Pediatrics*</td>
<td>Licensed Clinical Psychologists</td>
</tr>
<tr>
<td>• Obstetrics &amp; Gynecology*</td>
<td>Psychiatric Nurse Specialists</td>
</tr>
<tr>
<td>• General and Pediatric Psychiatry*</td>
<td>Licensed Clinical Social Workers</td>
</tr>
<tr>
<td>Medical Oncologists</td>
<td>Licensed Prof. Counselors of Mental Health</td>
</tr>
<tr>
<td>General Practice Dentists (DDS and DMD) in the state and surrounding areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Licensed Marriage &amp; Family Therapists</td>
</tr>
</tbody>
</table>

(Note - * Indicates an approved primary care specialty for physicians.)

- Through this program, the Higher Education Office is authorized to make awards for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education (i.e. principal, interest and related expenses for tuition and educational costs).

- Applications from practice sites seeking to recruit and hire a clinician under this loan repayment program or permitting such a clinician employed by another entity approved by the Delaware Health Care Commission to utilize the practice site’s facilities and staff while such clinician is providing medical care services as required under the terms and conditions of the State Loan Repayment Program are also accepted. Practice sites include public or private non-profit settings and private practices (solo or group) as well as State owned or operated facilities or institutions, including those where the geographic location of the facility or institution falls outside of a federally designated Health Professional Shortage Area (HPSA) but does house an underserved population or group. Loan Repayment funds may also be awarded to assist with loans for capital/equipment expenditures to establish a practice in an area of high need. For more information please contact the Program Coordinator at (302) 739-2730.

- Health professionals participating in this program must provide health services in a practice setting approved by the Delaware Health Care Commission. Initial contracts may be signed for a minimum of two (2) years and maximum of three (3) years. Participants may re-apply for contract extensions in one-year increments, not to exceed a total of four (4) years of loan repayment. Extensions will be granted at the discretion of the State Loan Repayment Review Committee and are contingent upon the availability of funds. Priority will be given to new applicants.
The Delaware State Loan Repayment Review Committee will review and rank applications in priority order. This will be based on the objective review of data (including public health indicators, the number and spatial distribution of providers practicing in Delaware, hospital needs assessments when applicable), the availability of funding and practice sites.

**Types of Loan Repayment Awards**

The Loan Repayment Program is funded through a combination of State and federal funds. Depending on the type and location of the practice site, some awards qualify to receive matching State and federal contributions and others are funded with State-only dollars. The same conditions and requirements apply to both types of loan repayment awards.

- State & federal funds – must be a non-profit, public facility or practice located in a designated health professional shortage area.

- State-only funds – private, for-profit facility or practice, as well as State owned or operated facilities or institutions, and awards for capital/equipment loans.

**Tax Implications**

- State & federal funds – according to an interpretation of a recent amendment to the Federal Public Health Service Act, qualifying loan repayment awards funded with matching State & federal dollars awarded on or after January 1, 2004 are exempt from federal gross income and employment taxes. Additionally, the State of Delaware follows the federal regulations so that qualifying loan repayment funds are also exempt from Delaware State income tax.

- State-only funds – awards funded with non-qualifying State-only dollars may constitute a taxable event subject to State and federal taxation on the total award amount. Participants receiving State-only funded awards will receive a Tax Form 1099 for each year they receive a loan repayment award.

Recipients will be notified at the time of award, and prior to signing a contract, whether their award contains qualifying State & federal dollars OR State-only dollars. All loan repayment award recipients are strongly advised and urged to contact their own tax professional for information and advice regarding the possible tax implications specific to their personal financial circumstances and loan repayment awards.

**Default Provision**

Loan repayment recipients whose awards contain **State and federal funds** must agree to the following provision. Should the participant breach the loan repayment 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 amounts paid by the SLRP to, or on behalf of, the participant for loan repayments for any period of obligated service not served;

- b. An amount equal to the product of the number of months of obligated service not completed multiplied by $7,500; 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.
Award Amounts

- **Advanced-degree Practitioners** may be granted up to $70,000 total for a two (2) year commitment, or $105,000 for a three (3) year contract.*

- **Mid-level Practitioners** may be granted up to $35,000 total for a two (2) year commitment, or $52,500 maximum for a three (3) year contract.*

* Please note that these figures represent the maximum award possible over 3 years; they are not guaranteed levels of funding. **Average** awards for advanced-degree practitioners range from $25,000 - $35,000 for a two year contract. Average awards for mid-level practitioners range from $10,000 - $15,000 for a two year contract. All awards are paid on a graduated scale.

**Distribution Formulae Tables**

**Advanced-degreed Practitioners** – payments will be made in accordance to the table below.

<table>
<thead>
<tr>
<th>Service Year</th>
<th>Period</th>
<th>Award</th>
<th>Debt Repay $</th>
<th>Cumulative $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1st 6 mo.</td>
<td>1/10th</td>
<td>7,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>2/10th</td>
<td>14,000</td>
<td>(21,000)</td>
</tr>
<tr>
<td>2</td>
<td>1st 6 mo.</td>
<td>3/10th</td>
<td>21,000</td>
<td>(42,000)</td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>4/10th</td>
<td>28,000</td>
<td>(70,000)</td>
</tr>
<tr>
<td>3 (if applicable)</td>
<td>1st 6 mo.</td>
<td>1/2</td>
<td>17,500</td>
<td>(87,500)</td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>1/2</td>
<td>17,500</td>
<td>(105,000)</td>
</tr>
</tbody>
</table>

**Mid-level Practitioners** - payments will be made in accordance to the table below.

<table>
<thead>
<tr>
<th>Service Year</th>
<th>Period</th>
<th>Award</th>
<th>Debt Repay $</th>
<th>Cumulative $</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1st 6 mo.</td>
<td>1/10th</td>
<td>3,500</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>2/10th</td>
<td>7,000</td>
<td>(10,500)</td>
</tr>
<tr>
<td>2</td>
<td>1st 6 mo.</td>
<td>3/10th</td>
<td>10,500</td>
<td>(21,000)</td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>4/10th</td>
<td>14,000</td>
<td>(35,000)</td>
</tr>
<tr>
<td>3 (if applicable)</td>
<td>1st 6 mo.</td>
<td>1/2</td>
<td>8,750</td>
<td>(43,750)</td>
</tr>
<tr>
<td></td>
<td>2nd 6 mo.</td>
<td>1/2</td>
<td>8,750</td>
<td>(52,500)</td>
</tr>
</tbody>
</table>
Practice Site Requirements: Practice sites must meet the following conditions:

- Be located in a health professional shortage area identified by the Delaware Health Care Commission;
- Health care professionals, practicing in State owned or operated facilities or institutions, including those where the geographic location of the practice site falls outside of a federally designated Health Professional Shortage Area (HPSA), are eligible, utilizing State only funding.
- Be identified by the Delaware Health Care Commission as a loan repayment practice site;
- Be committed to employing a health professional or providing a health professional employed by another entity approved by the Delaware Health Care Commission full-time (minimum of 40 hours a week, or a minimum of 37.5 hours per week if serving or practicing in a State owned or operated facility or institution, not including time on-call or travel time, except in those instances where the clinician is providing full-time care to low income, homebound patients in an underserved area and for whom transportation to the clinician’s office is either unavailable or unreliable) for a minimum of two (2) years;
- Provide assurance that compensation to Loan Repayment Clinician(s) employed by the practice site will be comparable to prevailing rates in the area;
- Provide adequate documentation of the medical care that will be provided by the Loan Repayment Clinician; and
- Certify that the Loan Repayment Clinician will provide health care services to Medicare, Medicaid, State Children Health Insurance Program (S-CHIP), and uninsured patients.
- All practice site sponsors 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 medicine or dentistry in this or any other state, for unprofessional conduct as so defined in 24 Del. C. Sec. 1731(a);
- Practice sites must agree to allow all non-dental clinicians to participate in the Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. CHAP provides low cost or no cost primary care “medical homes” to individuals who are ineligible for the Diamond State Health Plan or the Delaware Healthy Children Program, yet within established income limits. Enrollment in CHAP also provides eligible individuals with access to a statewide network of medical subspecialty services. Other benefits currently under negotiation include discounted lab and x-ray services, and pharmaceuticals. CHAP recipients receive discounted medical services based upon their income. VIP II is a statewide network of private physicians who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services.
Health Professional Requirements: Applicants must meet the following conditions:

- Be a clinician practicing in an eligible specialty with United States citizenship or a legal permanent resident of the United States or be a selected refugee approved by the U.S. Attorney General;

For purposes of this Program and the required application requirements, proof of United States citizenship or permanent legal resident of the United States must be established by providing with this application a certified copy of one of the following documents: a birth certificate, naturalization papers, United States passport, or marriage certificate (for legal permanent residents). For selected refugees, a certified copy of the approval by the United States Attorney General shall be required.

- Be committed to providing full-time patient care (minimum of 40 hours a week, or 37.5 hours if serving or practicing in State owned or operated facilities or institutions, not including time on-call or travel time, except in those instances where the clinician is providing full-time care to low income, homebound patients in an underserved area and for whom transportation to the clinician’s office is either unavailable or unreliable) for a minimum of two (2) years in an underserved area;

- Establish residency within 30 minutes of the practice site or, in the case of physicians, meet the requirement of the hospital in the catchment areas for admitting privileges;

- Have a valid, unrestricted license to practice in the State of Delaware at the time the service obligation begins;

- Have not 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;

- Have not 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 medicine or dentistry in this or any other state, for unprofessional conduct as so defined in 24 Del. C. Sec. 1731(a). Such a bar to applying for the Delaware State Loan Repayment Program For Health Professionals shall occur if the applicant was disciplined by means of levying a fine or by the restriction, suspension or revocation, either permanently or temporarily, of the applicant’s certificate to practice medicine or dentistry, or by other appropriate action, which may include a requirement that the applicant who was disciplined must also complete specified continuing professional education courses.

- Have outstanding qualifying higher education loans that are not in default;

- All dentists must agree that a minimum of 20% 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 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.
• All **non-dental clinicians** must agree to participate in the Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. CHAP provides low cost or no cost primary care "medical homes" to individuals who are ineligible for the Diamond State Health Plan or the Delaware Healthy Children Program, yet within established income limits. Enrollment in CHAP also provides eligible individuals with access to a statewide network of medical subspecialty services. Other benefits currently under negotiation include discounted lab and x-ray services, and pharmaceuticals. CHAP recipients receive discounted medical services based upon their income. VIP II is a statewide network of private physicians who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services. To enroll in VIP II, call Wheeler & Associates at (302) 744-9267.

**Applications:** Applications are accepted from practice sites and health professionals on a continuous basis. Interested persons should contact:

- Loan Repayment Coordinator
- Delaware Health Care Commission
- Margaret O’Neill Building, Third Floor
- 410 Federal Street, Suite 7
- Dover, DE 19901
- Phone: (302) 739-2730
- Fax: (302) 739-6927
- Website: [http://dhss.delaware.gov/dhss/dhcc/slrp.html](http://dhss.delaware.gov/dhss/dhcc/slrp.html)

**Application Review and Approval Process:**

Loan Repayment Applications are reviewed in three steps over the course of about one month. Application due dates are posted and frequently updated on the website [http://dhss.delaware.gov/dhss/dhcc/slrp.html](http://dhss.delaware.gov/dhss/dhcc/slrp.html). These deadlines are binding and as such, no exceptions will be made; untimely applications will not be considered.

1. Loan Repayment Review Committee – preliminary review and recommendations
2. Delaware Institute for Medical Education and Research (DIMER) for medical applicants
   - Delaware Institute for Dental Education & Research (DIDER) for dental applicants
INTRODUCTION
The Delaware Health Care Commission (DHCC), in cooperation with the Delaware Health and Social Services (DHSS) and the Delaware Higher Education Commission (DHEC), administers the Delaware Loan Repayment Program. Each is committed to ensuring that quality health care is available to all residents of the State of Delaware.

The Delaware State Loan Repayment Program is designed to recruit health professionals to areas of the State that have been identified as underserved by the Delaware Health Care Commission. The program provides educational loan repayment assistance to clinicians approved for the program. These clinicians will work at an eligible practice site in Delaware, which must be located in an area identified by the DHCC as being medically underserved. Health professionals participating in this program must provide services full-time (a minimum of 40 hours per week, or a minimum of 37.5 hours per week if serving or practicing in a State owned or operated facility or institution) for a minimum of two (2) years. Contracts may be extended in one-year increments at the discretion of the Loan Repayment Review Committee.

The Delaware Loan Repayment Program procedures apply to the following:

- Practice sites seeking to hire an eligible health professional under this loan repayment program.
- Health professionals seeking loan repayment through employment at an existing practice site or with the intent to establish a solo/private practice.

APPLICATION PROCESS
(Practice Sites and Health Professionals)

Practice Site Application Requirements

A preliminary review of each application will be conducted by the Loan Repayment Program Coordinator to determine 1) if the practice site is located within a shortage area, as identified by DHCC, and 2) that the required documentation is complete unless it is a State owned or operated facility or institution housing an underserved population or group as is previously described herein. The preliminary review will be conducted solely for the purpose of determining the completeness of the application; the specific content provided in each of the components will not be considered. Incomplete applications will be returned immediately.

The Practice Site Application (Appendix A) must, at a minimum, include the following:

A. Practice Site Application Form (see Appendix A):

1. Facility Information: Provide the name, address, county, telephone number and fax number of the practice site interested in hiring a Loan Repayment Clinician. Also, indicate the type of practice site (i.e. group practice/solo practice, public, private not for profit, private for profit).

2. Practice Site: Provide the name, address, and county of actual practice site at which the Loan Repayment Clinician would practice, if different from the primary location of the practice site.
3. **Recruitment Contact:** Provide the name, address, phone number, fax number and the e-mail address of the individual responsible for clinician recruitment. All Loan Repayment Program correspondence will be directed to the person identified as the recruitment contact.

4. **Practice Site Data Regarding Active Clients:** Provide the total number of active patients at the practice site in the previous calendar year. Indicate total patients, as applicable, for primary care, specialty care and mental health services. Provide pro-rated or estimated annual totals if the practice site was not operational for the entire previous calendar year. For new practice sites, estimate the number of patients anticipated for the next year. Of the total number of patients, provide the percentage of all current patients, broken out by given age groups, making payment conventional insurance plans, Medicare, Medicaid or self-pay. Submit a sliding fee scale if applicable. In cases where individual negotiated payment arrangements are made, please indicate the number of patients treated in this manner and describe the general financial arrangements.

5. **Staffing Levels:** Provide the total number of budgeted full-time equivalent providers currently on staff. Also include the number of Loan Repayment Clinicians requested by specialty and the projected hire date of each.

6. **Practice Site Hours of Operation:** Indicate the normal operating hours of the practice site by the days of the week. If hours of operation vary by practitioner, please specify.

7. **Proposed Loan Repayment Clinician Weekly Work Schedule:** Indicate the proposed weekly work schedule of the proposed Loan Repayment Clinician(s). Include the number of hours (with start and end times) and the location (hospital/practice site). The schedule must indicate the amount of time the Loan Repayment Clinician is actually providing services; do not include travel or on-call time. A separate schedule must be included for each proposed loan repayment clinician.

B. **Retention:**
The practice site must provide written documentation of plans to retain the Loan Repayment Clinician in the service area upon completion of their service obligation. Specifically, this plan must include short-term and long-term strategies that will not only keep the clinician in the service area, but also will encourage the clinician to continue to practice the specialty for which he/she was hired, including but not limited to malpractice insurance, partnership opportunities, pension, annual and sick leave, market rate competitive salary and salary increases. Please limit the retention plan to one-page. **Applications submitted without a retention plan are deemed incomplete and will not be considered.**

C. **Practice Site Agreement:**
The director or applicant official of the practice site must initial each of the statements on the Practice Site Agreement (see Appendix A) indicating agreement to comply with all requirements of the Delaware Loan Repayment Program. The director or applicant official of the practice site must provide an original, dated application with a live signature (using blue ink). This signature binds the site to the information provided and verifies that the form has been completed with accurate and current information.
Health Professional Application Requirements

DHCC reserves the right to approve or decline any application.

Health Professional Applicants must meet the following conditions:

Be a clinician practicing in an eligible specialty with United States citizenship or a legal permanent resident of the United States or be a selected refugee approved by the U.S. Attorney General;

For purposes of this Program and the required application requirements, proof of United States citizenship or permanent legal resident of the United States must be established by providing with this application a certified copy of one of the following documents: a birth certificate, naturalization papers, United States passport, or marriage certificate (for legal permanent residents). For selected refugees, a certified copy of the approval by the United States Attorney General shall be required.

- Be committed to providing full-time patient care (minimum of 40 hours a week, or a minimum 37.5 hours per week if a State owned or operated facility or institution, not including time spent in travel and/or on-call) not including time on-call or travel time, except in those instances where the clinician is providing full-time care to low income, homebound patients in an underserved area and for whom transportation to the clinician’s office is either unavailable or unreliable) for a minimum of two (2) years in an underserved area;

- Establish residency within 30 minutes of the practice site or, in the case of physicians, meet the requirement of the hospital in the catchments areas for admitting privileges;

- Have a valid, unrestricted license to practice medicine in the State of Delaware at the time the service obligation begins;

- Have not 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;

- Have not 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 medicine or dentistry in this or any other state, for unprofessional conduct as so defined in 24 Del. C. Sec. 1731(a). Such a bar to applying for the Delaware State Loan Repayment Program For Health Professionals shall occur if the applicant was disciplined by means of levying a fine or by the restriction, suspension or revocation, either permanently or temporarily, of the applicant’s certificate to practice medicine or dentistry, or by other appropriate action, which may include a requirement that the applicant who was disciplined must also complete specified continuing professional education courses;

- Have outstanding qualifying higher education loans that are not in default;

- All dentists must 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. 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.

- All non-dental clinicians must agree to participate in the Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. CHAP provides low cost or no cost primary care "medical homes" to individuals who are ineligible for the Diamond State Health Plan or the Delaware Healthy Children Program, yet within established income limits. Enrollment in CHAP also provides eligible individuals with access to a statewide network of medical subspecialty services. Other benefits currently under negotiation include discounted lab and
x-ray services, and pharmaceuticals. CHAP recipients receive discounted medical services based upon their income. VIP II is a statewide network of private physicians who accept CHAP patients into their practices and serve as their health home or provide medical subspecialty services. To enroll in VIP II, call Wheeler & Associates at (302) 744 - 9267.

The Loan Repayment Health Professional Application (see Appendix B for application forms) must, at a minimum, include the following:

A. **Clinician Data Form:**

The Clinician Data Form must be completed and have attached the following:
- Copy of the Loan Repayment applicant’s curriculum vitae; and
- Evidence of a Delaware license or certification or application for such.

B. **Employment Contract:**

Self-employed and/or solo practitioners do not need to submit an employment contract. However, self-employed clinicians must clearly demonstrate their fiscal and administrative capacity to operate a medical practice.

A non self-employed clinician must enter into an employment contract with a practice site, which must, at a minimum, include the following:
- Name and address of the practice site located in the underserved area, as identified by DHCC, at which the clinician will provide medical services. If the Loan Repayment Clinician will practice at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the clinician will practice at each;
- A statement that the practice site will employ the clinician on a full-time basis (minimum of 40 hours per week or a minimum of 37.5 hours per week if a State owned or operated facility or institution), not including time spent in travel and/or on-call);
- Description of the Loan Repayment Clinician’s qualifications, proposed responsibilities and how his/her employment will meet currently unmet health care needs of a medically underserved community;
- If the Loan Repayment Clinician will be practicing in a medically underserved area as identified by DHCC that is based on a population group, the employer must provide adequate documentation of the care that will be provided to this group; and
- Certification that the Loan Repayment Clinician will provide health care services to Medicare, Medicaid and uninsured patients; and certification that all Physicians and the sponsoring physicians of a Physician Assistant will participate in the Voluntary Initiative Program (VIP II).

C. **Loan Information and Verification Form:**

The Loan Repayment Clinician must include a notarized ‘Loan Information and Verification Form.’ The document must contain the applicant’s live, **notarized** signature (in blue ink).
D. **Health Professional Loan Repayment Program Contract:**

The health professional must enter into a contract with the State of Delaware committing to comply with all program requirements, including the following:

- Practice full-time in the approved underserved area for a minimum of two (2) years;
- Notify DHCC in writing within 30 days prior of any contractual changes that result in termination of contract, change in practice scope, and/or relocation from a practice site approved in the application request;
- Request any move to a different practice site than that already approved in writing to DHCC at least thirty (30) days prior to the change. Requests to change location of practice will be reevaluated based on eligibility criterion and service area priorities; and
- Report all changes in practice location and/or scope as well as routine correspondence to the following:

  Loan Repayment Coordinator  
  Delaware Health Care Commission  
  410 Federal Street, Suite 7  
  Margaret O’Neill Building  
  Dover, DE 19901  
  Phone: (302) 739-2730  
  Fax: (302) 739-6927
PROGRAM EVALUATION

The Delaware Loan Repayment Program is intended to assist with the recruitment of health professionals in underserved areas of Delaware, as identified by the Delaware Health Care Commission (DHCC), and the subsequent retention of such clinicians. In an effort to monitor the program, DHCC will collect various data, which will be utilized for evaluation purposes in terms the effects of the program on clinician recruitment and retention and to monitor the compliance with program requirements. The opportunity to discuss the experiences with the Loan Repayment Program of both clinicians and practice sites is welcome at any point. The following periodic reporting mechanisms are designed to collect evaluation information:

A. **Practice Site Facility Visits:**
The Delaware Loan Repayment Program reserves the right to conduct site visits to ensure the clinician and the practice site remain in compliance with all program requirements. Site visits will be conducted periodically and may be unannounced.

B. **Clinician Annual Reporting Process:**
An annual reporting process is used to ensure that each Loan Repayment Clinician continues to practice the approved medicine type at the original site approved for the required two years. DHCC will forward an Annual Practice Report form (see Appendix D for a sample form) to the practice site within thirty (30) days of the anniversary of the Loan Repayment Clinician’s start date. The practice site must forward the completed, signed Annual Practice Report to DHCC within fifteen (15) working days of receipt. A new Annual Practice Report must be submitted for each year of practice obligation.

C. **Exit Interview:**
Each Loan Repayment recipient must complete an exit interview within ninety (90) days prior to completion of his/her two-year obligation, or at such point that the employment contract is terminated by either the practice site or the Loan Repayment Clinician. DHCC will conduct the exit interview, which will concentrate on the Loan Repayment Clinician’s experiences in Delaware and their future plans for practicing medicine.

**COMPLETED APPLICATIONS AND ASSOCIATED LOAN REPAYMENT PROGRAM CLINICIAN CORRESPONDENCE MUST BE SENT TO:**

- Loan Repayment Coordinator
- Delaware Health Care Commission
- 410 Federal Street, Suite 7
- Margaret O’Neill Building
- Dover, DE 19901
- Phone: (302) 739-2730
- Fax: (302) 739-6927
1. **Facility Information Site:**
   - Street Address: ________________________________
   - City: _____________ State: ___ Zip: _______ County: __________
   - Telephone Number: _____________________ Fax Number: _____________________
   - Group Practice: ☐ Public: ☐ Private For Profit: ☐ Private Non Profit: ☐

2. **Practice Site:** ________________________________
   - Street Address: ________________________________ Census Tract: ______
   - City: _____________ State: ___ Zip: _______ County: __________

3. **Recruitment Contact:** ________________________________
   - Street Address: ________________________________
   - City: _____________ State: ___ Zip: _______
   - Telephone Number: _____________________ Fax Number: _____________________
   - E-Mail Address: ________________________________

4. **Name of specific Loan Repayment Applicant being recruited by site, if applicable:**
   (i.e., to be employed by the practice site and not merely utilizing practice site facilities and staff)
   ________________________________

5. **Date of application:** ________________________________

6. **Practice Site Data Regarding Active Clients**

   Total Number of Patients Receiving the Following Services During the Previous Calendar Year:

   - Primary Health Care: ______ Specialty Care: ______  TOTAL: ______
   - General Dental Care: ______ Mental Health Care: ______
   - Pediatric Dental Care: ______ Other: ______

   Total Users in Previous Calendar Year Below 200% of Federal Poverty Level: ______
Please provide the percentage of patients at this practice site that fall under the following payment categories:

<table>
<thead>
<tr>
<th>MEDICAID or S-CHIP</th>
<th>MEDICARE</th>
<th>SELF-PAY (UNINSURED)</th>
<th>COMMERCIAL INSURANCE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
</tbody>
</table>

\[ = 100 \% \]

7. Staffing Levels

<table>
<thead>
<tr>
<th>AREA OF PRACTICE</th>
<th>STAFFING LEVEL</th>
<th># of Loan Repayment Clinicians Requested</th>
<th>PROJECTED HIRING TIMELINE (Please include estimated date if known)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full</td>
<td>Current</td>
<td>1-3 Months</td>
</tr>
<tr>
<td>PRIMARY CARE PHYSICIANS/ DENTISTS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Internal Medicine</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>General Pediatrics</td>
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<tr>
<td>Obstetrics/ Gynecology</td>
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<tr>
<td>Dentist</td>
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<td></td>
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<tr>
<td>Other (Please Specify)</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>SPECIALIST PHYSICIANS</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>(Please Specify Specialty Area)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Oncology</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>General Psychiatry</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Pediatric Psychiatry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (Please Specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### NURSE PRACTITIONERS
- Family Nurse Practitioners
- Adult Nurse Practitioners
- Geriatric Nurse Practitioners
- Pediatric Nurse Practitioners
- Women’s Health Nurse Practitioners
- Psychiatric Nurse Practitioners

### OTHER DISCIPLINES
- Physician Assistants
- Certified Nurse Midwives
- Dental Hygienist
- Dental Assistant
- Clinical Psychologists
- Clinical Social Workers
- Psychiatric Nurse Specialist
- Licensed Prof. Counselor
- Licensed Marriage & Family Therapists
- Other (Please Specify)

### Practice Site Hours of Operation

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME (Start and End)</th>
<th>TOTAL HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monday</td>
<td>AM:</td>
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<tr>
<td>Sunday</td>
<td>AM:</td>
<td>PM:</td>
</tr>
</tbody>
</table>
9. Proposed Loan Repayment Clinician Weekly Work Schedule:

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME</th>
<th>WHERE</th>
<th>TOTAL HOURS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(Start and End)</td>
<td>(Practice Site)</td>
<td></td>
</tr>
<tr>
<td>Monday</td>
<td>AM: PM:</td>
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<td>Tuesday</td>
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</tr>
<tr>
<td>Sunday</td>
<td>AM: PM:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Provide a separate work schedule for each Loan Repayment Clinician requested and specify the specialty of each.

**RETENTION**

Describe your short and long-range plan for the retention of a Loan Repayment Clinician during and beyond the required two-year obligation. Please use additional paper and be specific. In the event the Loan Repayment Clinician is not employed by the practice site applicant but is employed by another entity that has been approved by the Delaware Health Care Commission and said Clinician is merely utilizing the practice site applicant’s facilities and staff while such Clinician is providing medical care services as required under the terms and conditions of the State Loan Repayment Program, the practice site applicant need not describe either short or long-term retention of such Clinician until and unless such Clinician becomes employed by and under the direct control of the practice site applicant. Applications submitted without a retention plan are deemed incomplete and will not be considered unless the clinician is NOT employed by the Practice Site Applicant.
PRACTICE SITE AGREEMENT

The Delaware Health Care Commission (DHCC) is committed to ensuring that all Delaware residents have access to quality, affordable health care. Accordingly, DHCC is prepared to consider loan repayment applications on behalf of clinicians under certain conditions. The director or applicant official for the facility or practice site applying to the Loan 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 Loan Repayment Clinician will provide health care services for at least forty (40) hours a week or a minimum of thirty seven and a half (37.5) hours per week if a State owned or operated facility or institution (not including time spent in travel and/or on-call) at the practice site named in the application for a minimum of two (2) years, as agreed upon in the contract. No more than 8 of those hours per week may be devoted to practice-related administrative activities. The practice will include hospital treatment coverage appropriate to meet the needs of patients of the approved service site and to ensure continuity of care.

With the exception of obstetrician/gynecologists, at least 32 of the minimum 40 hours per week (or 30 of the 37.5 hours per week at a State owned or operated facility or institution) will be spent providing clinical services in the ambulatory setting at the 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.

Obstetrician/gynecologists will spend the majority of the 40 hours per week (not less than 21 hours per week) providing ambulatory care services at the approved practice site during normally scheduled office hours. The remaining hours will be spent providing inpatient care to patients of the approved practice site, and/or in practice-related administrative activities.

Administrative activities will not exceed 8 hours per week.

The practice site agrees to provide health services to Medicare, Medicaid, 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.

The practice site must allow all loan repayment 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.

Practice sites must agree to allow non-dental clinicians to participate in the Delaware Community Healthcare Access Program (CHAP) and the Voluntary Initiative Program Phase II (VIP II) sponsored by the Medical Society of Delaware. To enroll in VIP II, call Jessica Hedden, VIP Coordinator at the Medical Society of Delaware at (302) 224-5190.
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.

- Hospital privileges for inpatient practice shall be maintained.

**QUALITY OF CARE**

- The physician practice site has a credentialing program in place, including National Practitioner Data Bank Query to review references and verify licensure and certification status of all providers, whether employed by the practice site or a third party entity.

- 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. However, it will NOT be necessary to address retention of providers in those instances where providers are employed by third party entities and are not employed by and under the direct control of the practice site.

**PROVIDER EMPLOYMENT CONTRACT**

- Loan Repayment Clinicians shall practice only in the medically underserved area and at the practice site for which originally approved by the DHCC, unless a change is approved in writing by DHCC.

- The practice site shall inform DHCC about Loan Repayment Clinician vacancies, including resignations, termination, extended leave for providers, and filled/withdrawn status of recruitment needs. Notification shall be provided within 30 days prior to such occurrence, as or soon as it is known. The practice site shall document in writing all circumstances surrounding resignations and terminations of both Loan Repayment Clinicians employed by the practice site and those employed by a third party entity utilizing the practice site’s facilities and staff.

- The practice site agrees to cooperate with mail, telephone and/or site visits conducted by DHCC for the purpose of monitoring compliance with the Delaware Loan Repayment Program.
I certify that the information provided in this application is 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 recruitment and retention program.

Signature of Facility Director or Applicant Official: ______________________________

Title: ______________________________ Date: ______________________________
1. Full Name: (Please Print)__________ Date of Application: _______

2. Date of Birth: ______________ Place of Birth: __________________

3. US Citizen:  □ Yes OR □ No
   *For purposes of this Program and the required application requirements, proof of United States citizenship or permanent legal resident of the United States must be established by providing with this application a certified copy of one of the following documents: a birth certificate, naturalization papers, United States passport, or marriage certificate (for legal permanent residents). For selected refugees, a certified copy of the approval by the United States Attorney General shall be required.*

4. Present Home Address: _________________________________

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

6. Name of Desired Practice Site, if applicable _________________________________
   Address: _________________________________
   Employment Start Date at Practice Site: __________________________

7. Discipline: Indicate the specialty you’re interested in practicing and, if applicable, subspecialties and the percent of time devoted to each.  

   □ Primary Care- MD
   □ Primary Care- DO
   □ Medical Oncologist
   □ Pediatric Psychiatrist
   □ Dentist- DMD
   □ Dentist- DDS
   □ Dental Hygienist
   □ Certified Nurse Midwife
   □ Physicians Assistant
   □ Certified Nurse Practitioners
   □ Clinical/Counseling Psychologist
   □ Licensed Clinical Social Worker
   □ Psychiatric Nurse Specialists

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8. Proposed Service Commitment:
Participation in the Delaware Loan Repayment Program requires a minimum of two (2) years continuous full-time service. The maximum length of an initial contract is three (3) years. Please indicate the proposed length of your service commitment.

☐ Two (2) Years
☐ Three (3) Years

9. License:

Type: ________________________________
State: __________________________ Number: ________________________________
Date Issued: ___________ Expiration Date: ________________________________
Restrictions: ________________________________

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: ________________________________

10. Education (Please use additional paper as necessary)
College/Program: ________________________________
Address: ________________________________
__________________________________________________________________________
From: ___________________________ To: ___________________________
Degree/Diploma: ________________________________ Discipline: ________________________________
Contact Person: ________________________________
Telephone: (_____) ___________________
Graduate School: ____________________________________________________________
Address: ________________________________________________________________

_____________________________ To: ______________________________
From: ___________________________ Degree/Diploma: ____________________________

Discipline: ____________________________ Contact Person: ______________________
Telephone: ____________________________

Medical or Dental School: __________________________________________________
Address: ________________________________________________________________

_____________________________ To: ______________________________
From: ___________________________ Degree/Diploma: ____________________________

Discipline: ____________________________ Contact Person: ______________________
Telephone: ____________________________

11. 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: ________________________________________________________________

_____________________________ To: ______________________________
From: ___________________________ Degree/Diploma: ____________________________

Discipline: ____________________________ Contact Person: ______________________
Telephone: ____________________________

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

Name ___________________________________________ Name _________________________

12. 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? ________________________

13. Describe your education and practice experience, which you believe qualifies you to participate in the Delaware Loan Repayment Program. 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
- Physicians and dentists should discuss their collaborative practice experience and commitment to working with physician assistants, certified registered nurse practitioners, 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.

14. Language(s) Spoken Fluently

☐ English ☐ French
☐ Spanish ☐ German
☐ Arabic ☐ Chinese
☐ Indian ☐ Other (please specify) ________________________
15. **Race/Ethnicity** (collected for workforce research purposes only)

- [ ] Black, not of Hispanic origin
- [ ] Asian
- [ ] Hispanic
- [ ] American Indian, Alaskan Native
- [ ] White
- [ ] Pacific Islander, Native Hawaiian
- [ ] Other (please specify) ______________

16. **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

17. **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 five (5) being your last.

- [ ] New Castle County – Northern
- [ ] New Castle County – 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 three (3) being your last.

- [ ] Urban
- [ ] Suburban
- [ ] Rural

18. **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.

19. **What date are you available for service?** ____________________________

20. **How did you hear about the Delaware State Loan Repayment Program?** ________________

21. **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 Loan Repayment Applicant  Date
APPENDIX C
DELAWARE LOAN INFORMATION AND VERIFICATION FORM

The following information must be provided to your lender and the Delaware State Loan Repayment Program:

**Step 1.** Complete PARTS A, B for each loan
**Step 2.** Complete PART C (Page C-3) in BLUE ink and have notarized.
**Step 3.** Send directly to your lender: Original PARTS A and B along with a photocopy of PART C.
**Step 4.** Send to the Delaware State Loan Repayment Program: Photocopies of PARTS A and B for each loan and the original signed (BLUE ink) and notarized PART C.

The Delaware State Loan Repayment Program is not responsible for submitting paperwork to your lender.

PART A – TO BE COMPLETED BY APPLICANT

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

<table>
<thead>
<tr>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tr>
</tbody>
</table>

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 of 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’Neel Building, Third Floor, 410 Federal Street, Suite 7, Dover, DE 19901. Phone: (302) 739-2730, or Fax: (302) 739-6927

Printed Name of Loan Repayment 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 SHOULD SUBMIT TO LENDER FOR VERIFICATION

The individual identified on this form has applied to participate in the 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). 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:  ________________________

C-2
PART C

Delaware Institute for Dental Education and Research
Delaware Institute for Medical Education and Research
Delaware Health Care Commission
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. __________________________________________________________
2. __________________________________________________________

Lenders/Guaranty Agencies/Loan Servicers:
1. __________________________________________________________
2. __________________________________________________________
3. __________________________________________________________
4. __________________________________________________________

________________________________________________________________
________________________________________________________________

________________________________________________________________
________________________________________________________________

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________________________________________________________________

________________________________________________________________
________________________________________________________________

Student’s Signature
(use BLUE ink)

Printed Name of Student

Notary Seal

Social Security Number

Date

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APPENDIX D
EXAMPLE: DELAWARE LOAN REPAYMENT PROGRAM
ANNUAL PRACTICE REPORT

1. Name of Loan Repayment Applicant: ____________________________
   Start Date: ____________________

2. Facility Information: ____________________________
   Street Address: ____________________________
   City: _______ State: _____ Zip: _______ County: _______
   Telephone Number: ______________ Fax Number: ______________
   Non-Profit: ______________ For Profit: ______________

3. Practice Site: ____________________________
   Street Address: ____________________________
   City: _______ State: _____ Zip: _______ County: _______

4. Contact Person: ____________________________
   Street Address: ____________________________
   City: _______ State: _____ Zip: _______
   Telephone Number: ______________ Fax Number: ______________
   E-Mail Address: ____________________________

Type of Service(s) Provided:

Please provide the medical specialties practiced by the Loan Repayment Clinician, the location and total hours he/she worked in each specialty and the number of annual visits performed by this clinician for each specialty practiced (include all primary care and other medical specialties).

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>Location</th>
<th>Total Hours/Week</th>
<th>Annual Visits</th>
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<tbody>
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D-1
Loan Repayment Clinician’s Hours of Operation:

Indicate the weekly work schedule of the Loan Repayment Clinician. Include the number of hours (with start and end times) and the primary location (hospital/practice site). The schedule must indicate the time the Loan Repayment Clinician is actually providing services; do not include travel or on-call time. If the Loan Repayment Clinician is practicing at more than one location, please complete a schedule for each location.

<table>
<thead>
<tr>
<th>DAY</th>
<th>TIME (Start and End)</th>
<th>TOTAL HOURS</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Sunday</td>
<td>AM:</td>
<td>PM:</td>
</tr>
</tbody>
</table>

Practice Site Data Regarding Active Clients:

Provide the total number of active patients at the practice site in the previous calendar year with totals, as applicable, for primary care, specialty care and mental health services.

Total Number of Patients Receiving the Following Medical Services:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

General (Adult) Dental Care_____
Pediatric Dental Care_____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level (to the extent known) _____

Please provide the percentage of patients at this practice site that fall under the following payment categories:

<table>
<thead>
<tr>
<th>MEDICAID or S-CHIP</th>
<th>MEDICARE</th>
<th>SELF-PAY (UNINSURED)</th>
<th>COMMERCIAL INSURANCE</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>%</td>
<td>%</td>
<td>%</td>
<td>= 100%</td>
</tr>
</tbody>
</table>

This will certify that _________________________ (name of Loan Repayment Clinician) provided medical services to patients at the approved health facility site on a full-time basis (minimum thirty-seven and one-half (37.5) hours per week) for the time period of ____________ through ____________.

Signature of Applicant Official: ____________________________ Date: ____________________________

Title: ____________________________