|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Name of Loan Repayment Applicant:** | | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | Start Date: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | |  | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | **Facility Information:** | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | Street Address: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | City: | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | State: | \_\_\_\_\_\_ | Zip: | | \_\_\_\_\_\_\_ | | | County: | \_\_\_\_\_\_\_\_\_ |
|  |  | | | | | | | | | | |  | | | | | | |
|  | Telephone Number: | | | | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Fax Number: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | Non-Profit: | | |  | | | | | | | | Public: | | |  | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | **Practice Site:** | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | Street Address: | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | |
|  |  | | | | | | | | | | |  | | | | | | |
|  | City: | \_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | State: | \_\_\_\_\_\_ | Zip: | | \_\_\_\_\_\_\_ | | | County: | \_\_\_\_\_\_\_\_\_ |
|  |  | | | | | | | | | | |  | | | | | | |
|  | **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).

|  |  |  |  |
| --- | --- | --- | --- |
| Practice Type | Location | Total Hours/Week | Annual Visits |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**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.

|  |  |  |  |
| --- | --- | --- | --- |
| 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 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** | | | 0 | | |
|  | | | | | | |
| 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:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICAID or S-CHIP | MEDICARE | SELF-PAY (UNINSURED)  NEGOTIATED/ REDUCED FEE or FREE SERVICE | COMMERCIAL INSURANCE | TOTAL |
| % | % | 7% | % | = 100 % |

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 forty (40) hours per week) for the time period of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ through \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Signature of Applicant Official: | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
|  |  | |  | | | |
| Title: | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |