APPLICATION PART C
DELAWARE STATE LOAN REPAYMENT PROGRAM
LOAN VERIFICATION FORM

INSTRUCTIONS

The following information must be provided to your loan (lender) institution for formal verification and to Delaware State Loan Repayment Program for eligibility determination on or before the application deadline.

1. Complete Sections I & II for EACH loan.
   a. Ensure Section I is completed and signed before forwarding the packet to the Lending Institution for verification and authorization.
   b. Ensure Lending Institutions are aware of the signature line and contact information at the bottom of Section II. Applicants should allow one to three weeks for Lending Institutions to complete and submit Section III to Delaware Health Care Commission.

2. Complete Section III sign in BLUE ink and notarize. (Release of Information Form)

3. Send Sections I-III DIRECTLY to your lender:
   a. Section I – Must have Applicant’s Signature
   b. Section II – Request verification of information and Lender’s Authorized Representative’s Signature
   c. Photocopy of Section III (for EACH Lender) – Notarized

4. Send to Delaware State Loan Repayment Program:
   a. Final copies of Section I (for EACH Lender)
   b. Final copies of Section II – coordinate with Lender (for EACH Lender)
   c. Original Section III signed in BLUE ink and notarized

5. Follow up with Delaware Health Care Commission prior to the application due date to ensure a complete application packet was submitted on time.

The Delaware State Loan Repayment Program is NOT responsible for submitting paperwork to your lender(s). Applicant MUST work with lending institutions to ensure this Loan Verification Form is submitted to Delaware Health Care Commission on or before the application due date. Outstanding Loan Verification Forms received after the application due date are ineligible for consideration in this program.
Section I: SLRP Applicant

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

Applicant: ____________________________________________________________
Institution: __________________________________________________________
Address: ___________________________________________________________________

Date of Loan: ___________________________ Account Number: ___________________________
Original Amount of Loan: __________________ Current Balance: __________________
Number of Payments Made: __________________ Date of Balance: __________________
Payment Amount: __________________ Interest Rate: __________________
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 an academic year as defined by the US 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 Delaware Institute for Dental Education and Research (DIDER) and Delaware Institute for Medical Education and Research (DIMER) are ineligible for repayment. The Delaware State Loan Repayment Program will only pay toward the educational costs associated with the health professional degree, and a determination will be made of the proportion of a consolidation loan that will be paid for successful applicants.

**Applicant Certification:**

I hereby certify to the accuracy of the above information and apply to enter into an agreement with the Delaware State Loan Repayment Program for repayment of educational loans, incurred solely for the costs of education in 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 above to release this information about the loan listed 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
Section II: Loan Verification (Institution)

Dear Lender:

The individual identified on this form has applied to participate in the Delaware State Loan Repayment Program (SLRP). SLRP is designed to improve 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 in Section I is a bona fide legally enforceable commercial, Federal, State, or government educated loan obtained for the purpose of meeting the borrower’s cost of attending undergraduate or graduate school, of dentistry, medicine, or a school of osteopathy (for tuition, educational expenses, or living expenses from a college, university, government or commercial source).

I am requesting that your institution actively review the complete loan compliance, sign Section II in this application and submit the information requested as soon as possible to the following organization.

ATTN: SLRP Program Director
Delaware Health Care Commission
Margaret O’Neil Building, Third Floor
410 Federal Street, Suite 7
Dover, DE 19901

Phone: 302-739-2730
Fax: 302-739-6927
Email: DHCC@state.de.us

Retain a copy of this form for your records.

Delaware requests financial verification of information submitted in Section I of this Loan Verification Form. According to your records, include any corrections in the “comment” space provided below, and attach clearly identifiable system generated printouts as proof of the applicant’s loan information.

Note: In the event of a State and/or Federal audit, the certifying agent and/or organization below is held answerable for all inquiries.

Comments: __________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
__________________________________________________________
APPLICATION PART C
DELAWARE STATE LOAN REPAYMENT PROGRAM
LOAN VERIFICATION FORM

Applicant Loans are in Good Standing ☐ Yes ☐ No
Applicant Loans are Delinquent ☐ Yes ☐ No
Supporting Attachments Included: ☐ Yes ☐ No
Total Number of Pages Attached: _______________________

This Lending Institution has a registered W-9 Form with the State of Delaware (http://mymarketplace.delaware.gov/resources/vendor.shtml), and as such, has an active ten-digit vendor identification number: ______________________ Contact (302) 526 – 5600 for assistance.

**Lender Certification:**

I am an authorized financial representative of the mentioned Lending Institution in Section I of this Loan Verification Form. I hereby certify accuracy of the loan information contained within this document, as corrected by my notations and/or comments, and within any supplemental documents provided as a result of this verification. In the event of an inquiry, the information below, and contained in this request, will be provided to the inquiring party.

Applicant (Loan Recipient): ______________________________________
Loan Institution: _________________________________________________

Date of Loan: ________________________ Account Number: ______________
Original Amount of Loan: ______________ Number of Payments Made: __________
Current Balance: ______________ Date of Balance: ______________
Payment Amount: ______________ Interest Rate: ______________
Purpose of Loan (as indicated on loan application): ____________________________

Total Amount of Loan Per Account Number: __________________________________

Signature: ____________________________ Title: ____________________________
Lending Institution Representative Financial Manager
Name: ________________________________ Date: ____________________________
Print Clearly
Address: ________________________________ Phone: ______________________
_________________________________ Email: ___________________________
Section III: Notary (send original to DHCC - 410 Federal St. - Margaret O’Neill Building - Dover, DE 19901)

Delaware Health Care Commission
Request to Release Personally Identifiable and Confidential Information

I ___________________________, hereby waive my rights under the Family Educational Rights and Privacy Act (FERPA) and authorize the State of Delaware, Department Health and Social Services, Office of the Secretary, Delaware Health Care Commission (Delaware), acting in an administrative capacity for the Delaware State Loan Repayment Program (SLRP), to receive requested confidential or non-confidential information concerning my educational loan account(s) and other “non-directory” information pertinent to my application for SLRP. Consent is deemed continuous unless revoked by me in writing. Educational and Loan institutions below are directed to release all needed information to Delaware.

Educational Institutions (Schools):
1. __________________________________________
2. __________________________________________

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

Applicant’s PRINTED Name

Social Security Number (Required)

Applicant’s Signature (use BLUE ink)

Date

Notary Seal

Notary Signature / Date