The Delaware Health Care Commission administers two loan repayment programs specifically targeted toward healthcare professionals in primary care, dental, behavioral/mental health, and substance use disciplines.

1. ***NEW*** **Delaware Health Care Provider Loan Repayment Program (HCPLRP)** – this program is funded by the State of Delaware. The maximum award amount for awarded practitioners is up to $200,000 for a four-year commitment. Practitioner must have graduated from a medical institution or residency program within six (6) months of submitting a HCPLRP application.

2. **Delaware State Loan Repayment Program (SLRP)** – This program is funded through a three-year federal grant award totaling $225,000 annually. The maximum award amount for advanced degreed practitioners is up to $200,000 for a four-year commitment and $120,000 for mid-level degreed practitioners. Among other requirements, practitioners must be employed in a federally designated Health Professional Shortage Area.

Eligible applicants must provide services in the following specialty environments:

- Family Medicine
- Geriatrics
- Gynecology
- Internal Medicine
- Pediatrics
- Psychiatry
- Obstetrics
- Osteopathic Medicine
- Women's Health

Applications are evaluated on qualitative and quantitative scoring metrics based on the information received in applications. Eligible applicants are awarded according to availability of funding.

Additional information is available online: https://dhss.delaware.gov/dhcc/lrp.html

Contact DHCC@Delaware.Gov or (302) 255-4750 to follow up on submitted applications.

Please note: SLRP applicants must complete this form in its entirety for complete assessment of the application. HCPLRP applicants may skip the questions labeled SLRP applicant only.

Application Information

Select which loan repayment program for which you are applying?

- ❑ State Loan Repayment Program (SLRP) – Answer all application questions
- ❑ Health Care Provider Loan Repayment Program (HCPLRP)
- ❑ Unsure - *Answer all questions in the application. DHCC will determine based on information contained in the application which program is suitable.*

Select the following applicant status and level of commitment to the program:

- ❑ New Application – 2 Year Commitment
- ❑ Continuing Application – select commitment level below:
  (SLRP applicants are limited to 1 Year Commitments only)
- ❑ *1 Year Commitment* ❑ *2 Year Commitment*
- ❑ Previous Application Not Awarded

Date of the Application:

Applicant Contact Information

Current Name:

Former Name (if applicable)

Permanent Address:

Home Phone:

Mobile Phone:

Email Address:

Eligibility / Evaluative Scoring / Reporting Information

United States Citizenship: ❑ Yes ❑ No

❑ Conrad 30/J-1 Visa Participant **(HCPLRP applicants only)**

Date of Birth:

Place of Birth:

Years Residing in Delaware: ❑ 0-2 ❑ 2-4 ❑ 4-6 ❑ 6+

Employment Information

Organization Name:

Direct Supervisor/Title:

Physical Address:

County:

Direct Phone Number:

Email Address:

Number of Clinical Hours Per Week:

Number of Administrative Hours Per Week:

Number of Training Hours Per Week:

Number of Teaching Hours Per Week:

Select Area of Specialty:

- ❑ Adult Medicine
- ❑ Behavioral Health
- ❑ Family Medicine
- ❑ Geriatrics
- ❑ Gynecology
- ❑ Internal Medicine
- ❑ Mental Health
- ❑ Pediatrics
- ❑ Psychiatry
- ❑ Obstetrics
- ❑ Osteopathic Medicine
- ❑ Women's Health

Select Area of Eligible Discipline: (**blue** font qualify for HCPLRP, **black** for SLRP)

Mid-Level Degree Disciplines

- ❑ Certified Nurse Midwife (CNM)
- ❑ Certified Nurse Specialists (CNS)
- ❑ Health Service Psychologist (HSP)
- ❑ Licensed Alcohol/Drug Counselor (LADC)
- ❑ Licensed Clinical Social Worker (LCSW)
- ❑ Licensed Professional Counselor (LPC)
- ❑ Marriage and Family Therapist (MFT)
- ❑ Nurse Practitioner (NP)
- ❑ Pharmacist (PharmD)
- ❑ Physician Assistant (PA)
- ❑ Psychiatric Nurse Specialist (PNS)
- ❑ Registered Dental Hygienist (RDH)
- ❑ Registered Nurse (RN)

Advanced Degree Disciplines

- ❑ Allopathic Medicine (MD)
- ❑ Osteopathic Medicine (DO)
- ❑ Doctor of Dental Surgery (DDS)
- ❑ Doctor of Medicine in Dentistry (DMD)

Professional License ID:
License Type:
State Issued: (*Specify:*)
Date Issued:
Expiration Date:
Restrictions:
National Provider Identifier (NPI):

SLRP applicant only. Do you provide Substance Use Disorder (SUD) Services? ❑ Yes ❑ No
SLRP applicant only. Are you a DATA 2000 Waiver Provider? ❑ Yes ❑ No

Professional License ID:
License Type:
State Issued: (Specify:)
Date Issued:
Expiration Date:
Restrictions:

Do you provide Telehealth Services? ❑ Yes ❑ No

Are you Dental/Medical Board Eligible? ❑ Yes ❑ No
Are you Dental/Medical Board Certified? ❑ Yes ❑ No
Date of Certification:
Name of Board:
Sub-Specialty Board:

Are there existing/pending disciplinary actions? ❑ Yes* ❑ No
Has your license ever been suspended or revoked? ❑ Yes* ❑ No

Do you, or have you had, any federal judgement liens, defaults, debt write-offs, uncollected debt, waiver, or others? ❑ Yes* ❑ No

SLRP Only: Have you secured a 50% match from the State of Delaware or from your employer? ❑ Yes* ❑ No ❑ N/A

HCPLRP Only: If you work for a Delaware Hospital System (Bayhealth, Beebe Healthcare, ChristianaCare, Nemours Children's Hospital, Saint Francis Hospital, or TidalHealth Nanticoke) a 50%, dollar-for-dollar match is required for the award. If applicable, have you secured this match? ❑ Yes* ❑ No ❑ N/A

Have you ever been convicted of, or pled guilty to, a felony as defined under either Federal or State law and as enumerated in **11 Del.C. § 4201?** ❑ Yes* ❑ No

Do you have an existing service obligation? ❑ Yes* ❑ No

SLRP applicant only. Have you breached a services obligation, even if it was subsequently satisfied? ❑ Yes* ❑ No

* If you answered yes to any of the above questions, please explain and provide date the issue or obligation was/will be resolved:

SLRP applicants only. Attach a full self-query from the National Practitioner Data Bank (NPDB). The NPDB is an information clearinghouse created by Congress with the primary goals of improving health care quality, protecting the public, and reducing health care fraud and abuse in the United States. NPDB information is intended to be used in combination with information from other sources when entities are making decisions regarding licensure, employment, contracting, membership or clinical privileges, or when conducting investigations. ❑ Attached ❑ Not Attached

Undergraduate Education

Educational Institution:

Institution Address:

Attendance Dates:

Date of Graduation:

Degree/Certification:

Graduate Education

Educational Institution:

Institution Address:

Attendance Dates: Start End

Date of Graduation:

Degree/Certification:

Dental / Medical Education

Educational Institution:

Institution Address:

Attendance Dates: Start End

Date of Graduation:

Discipline:

Did you participate in either Delaware Institute of Dental/Medical Education and Research Programs (DIDER or DIMER)? ❑ Yes ❑ No ❑ Unsure

Dental / Medical Residency Program (respective to discipline/specialty for this application and programs completed at a Delaware-based healthcare facility)

1. Educational Institution:

Institution Address:
Attendance Dates: Start End
Date of Graduation:
Discipline:
Specialty:

2. Educational Institution:

Institution Address:
Attendance Dates: Start End
Date of Graduation:
Discipline:
Specialty:

Additional education history shared separately: ❑ Attached ❑ Not Attached

What is the combined total of all educational loans in your name? Please include all federal, private, commercial, and consolidated/refinanced student loans.

Demographic Data

Are you an honorably discharged United States Veteran? ❑ Yes ❑ No

SLRP applicants only.

❑ I am not a certified Medical Interpreter

❑ I am a certified Medical Interpreter
Attach a legible copy of certification.

Medically Fluent Languages

- ❑ Arabic
- ❑ English (Mandatory)
- ❑ Chinese
- ❑ French
- ❑ German
- ❑ Indian
- ❑ Spanish
- ❑ Haitian Creole
- ❑ Other
  (Specify:)

Race/Ethnicity

- ❑ Asian
- ❑ Black / African American
- ❑ White / Caucasian
- ❑ Hawaiian
- ❑ Hispanic
- ❑ Native American Indian and Alaskan Native
- ❑ Other Pacific Islander and Native Hawaiian
- ❑ Other
  (Specify:)

Have you ever lived in a rural area, a geographical area located in a non-metropolitan county, or an area located in a metropolitan county designated by the Federal Office of Rural Health Policy as rural? ❑ Yes* ❑ No

* If yes, address

As defined by the Scholarship for Disadvantaged Students program, have you been identified as having a disadvantaged background based on education, environment and/or economic factors, or did you receive a federal Exception Financial Need Scholarship?

❑ Yes ❑ No

If yes, please select one or more of the following:

Environmentally Disadvantaged: A person's environment inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school. ❑ Yes ❑ No

Economically Disadvantaged: A person from a family with an annual income below a level based on low-income thresholds, according to family size established by the U.S. Census Bureau. ❑ Yes ❑ No

Educationally Disadvantaged: A person who comes from a social, cultural, or educational environment that has demonstrably and directly inhibited the person from obtaining the knowledge, skills, and abilities necessary to develop and participate in a health professions education or training program. ❑ Yes ❑ No

How did you hear about Delaware Health Care Provider Loan Repayment Program?

How did you hear about Delaware State Loan Repayment Program?

Certification

I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I authorize the Delaware Health Care Commission to contact references and program directors listed in the application for the purpose of obtaining information about my professional qualifications, experience, abilities, and criminal history background. I understand that information provided is subject to verification, serves the same purpose as a legal signature, and is binding.

- I certify, as required in the application, that I have read and understand all application instructions, including the provisions which note that I am responsible for monitoring and ensuring the progress of my application.
- I certify that I have read and will abide by all program-specific instructions for successful participation in the program.
- I certify that all information and statements provided in this application are current, correct, and complete to the best of my knowledge.
- I certify that my personal information on the application represents my own work.
- I understand that withholding information requested on the application, or giving false information, may be grounds for denial of the application and further award consideration.
- I consent to the disclosure of the contents of this application to a Review Committee comprised of public and private sector members of the healthcare industry for the purpose of determining loan repayment program eligibility and level of any loan repayment program award.
- I understand and acknowledge that the review of this application and the determination of whether an award is granted or not is discretionary in nature and in the event, after review of this application, a decision is made not to approve this application for an award, the State of Delaware, its employees and agents, and any other individuals or organizations involved in the review process for this application shall be held harmless from any and all liability, suits, actions or claims arising from or related to in any way the review process for this application and determination of an award (if any)
- I agree, understand and consent to information collected in this application, and future surveys associated with this program, will be used for statistical purposes; such as educational research used to improve the program guidelines.
- I acknowledge and agree that my sole remedy in the event of any proven errors or omissions related to the handling or processing of my application by Delaware Health Care Commission is to submit written notice to DHCC@delaware.gov within fifteen (15) days of the event.
- I agree not to submit more than one (1) completed application during the application cycle, and acknowledge that any duplicate applications I create or submit may be disregarded by Delaware Health Care Commission.

Signature of Applicant Date

RESOURCE MATERIAL

Application Checklist: This checklist was developed to help you submit a complete application in one attempt. Please ensure the following documents are attached and submitted to DHCC@Delaware.Gov on, or before, the application due date:

❑ Application Includes Parts A and C

❑ Being sent separately from organization/company with authorized signatures

❑ Application, Part B (must have applicant signature and all sections completed)

❑ Proof of Citizenship/Driver's License (color photocopy) / Conrad 30/J-1 Visa Waiver

❑ Curriculum Vitae (CV) or Resume

❑ Copy of Highest Degree/Certification Obtained (color photocopy)

❑ Copy of Health Professional License (State of Delaware)

❑ Copy of DATA 2000 Waiver (if applicable)

❑ Self-Query from the federal National Practitioner Data Bank – NPDB (if applicable)

❑ DD214 Veteran Status

❑ Miscellaneous Documents (education history, Medical Interpreter Certificate, etc.)

If above documents are not included in this application submission, please explain: