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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| MEDICAIDorS-CHIP | MEDICARE | SELF-PAY (UNINSURED)NEGOTIATED/ REDUCED FEE or FREE SERVICE | COMMERCIALINSURANCE | 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: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |