Practice Site Application and Declaration of Intent

Michigan State Loan Repayment Program
Michigan Department of Health and Human Services

Today's Date_____

1. Sponsoring Agency Information

a. Name of Sponsoring Agency:		b. Federal ID #:	
c. Address	d. City	e. State	f. Zip
g. Administrator Name	h. Title	i. County	
j. Administrator Email:	k. Administrator Direct Phone:		

l. Name & Email of assistant, HR staff or recruiter that will be copied on correspondence directed to the administrator:
Name: Email:

Type of Sponsoring Agency (e.g. health system, medical group, local public health, etc.):

2. Provider & Agreement Information

Provider (Applicant) Last Name:	Provider (Applicant) First Name:	Middle Name:

Provider (Applicant) Title:
☐ MD ☐ DO ☐ Certified Nurse Mid-wife ☐ Nurse Practitioner ☐ Physician's Assistant
☐ Masters of Social Work (MSW) ☐ DDS/DMD ☐ Psychologist ☐ Counselor

Provider Applicant Discipline/Specialty:
☐ Family Practice ☐ Obstetrics/Gynecology ☐ Pediatrics ☐ Internal Medicine
☐ Mental Health ☐ Geriatrics

Provider (Applicant) Employment Start date or Expected start date:	Provider (Applicant) Email:

This MSLRP agreement will be used for: ☐ Provider Recruitment ☐ Provider Retention

Select the statement below that best describes your agreement with the MSLRP applicant regarding employer contributions. This employer is:

☐ Not-for-profit and agrees to contribute 20 percent (20%) of the total amount of any loan repayment agreement I may be awarded.

☐ Located within Genesee County and the 20 percent (20%) contribution is waived.

☐ For-profit and agrees to contribute 50 percent (50%) of the total amount of any agreement. Providers must work in a non-profit practice site.

☐ My employer has not agreed to make employer contributions. **(Will be screened out of current application period.)**

You may request priority status to receive preference in the MSLRP selection process by checking the box indicating your provider type, below (see instructions for additional information):

☐ Northern Obstetric Service Providers

☐ Psychiatrist (out-patient, clinic-based)

☐ Inpatient Pediatric Psychiatric Providers (See 2018 MSLRP Update)

☐ Genesee County Primary Care Providers (See 2018 MSLRP Update)

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3. Practice Site Information

a. Will the MSLRP applicant be employed at the practice site(s) listed below for a total of at least 40 hours per week for no less than 45 weeks per year?

☐ Yes ☐ No

Note: Time 'on call' does not count toward 40 hours of employment per week.

b. Are all of the practice sites listed below not-for-profit?

☐ Yes ☐ No

c. Practice Site 1

Name of Practice Site:			
Physical Address:			
City:	County:	State:	**9-Digit Zip:**
Number of hours per week that provider will be employed at this site:			
If this practice site is under construction, what is the estimated opening date:			
Practice Site Manager Name:	Practice Site Manager Email:		
Practice Site Manager phone:			

Check **ALL** of the following that describe the Practice Site:

- ☐ Certified Rural Health Clinic designated as a facility HPSA (CRHC/HPSA See Instructions)
- ☐ Certified Rural Health Clinic not designated as a facility HPSA
- ☐ Community Health Center (CHC)
- ☐ Community Mental Health Clinic
- ☐ Critical Access Hospital-Affiliated Primary Care Clinic
- ☐ Federally Qualified Health Center (FQHC) "Look-Alike"
- ☐ Hospital-Affiliated Primary Care Clinic (Non-Critical Access)
- ☐ My Community Dental Centers
- ☐ Other Not-for-Profit Primary Care Clinic designated as a facility HPSA
- ☐ Private/For-Profit Clinic (Eligible only for NHSC, **not** MSLRP.)
- ☐ Private/Not for Profit Primary Care Clinic
- ☐ State-funded Primary Care Clinic
- ☐ State Psychiatric Hospital
- ☐ State/Federal Correctional Facility
- ☐ Tribal-Affiliated Primary Care Clinic
- ☐ Local Health Department
- ☐ Hospital child/adolescent inpatient psychiatric unit

Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?

Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?

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d. Practice Site 2 (If applicable)			
Name of Practice Site:			
Physical Address:			
City:	County:	State:	**9-Digit Zip:**
Number of hours per week that provider will be employed at this site:			
If this practice site is under construction, what is the estimated opening date:			
Practice Site Manager Name:	Practice Site Manager Email:		
Practice Site Manager phone:			

Check **ALL** of the following that describe the Practice Site:

- ☐ Certified Rural Health Clinic designated as a facility HPSA (CRHC/HPSA See Instructions)
- ☐ Certified Rural Health Clinic not designated as a facility HPSA
- ☐ Community Health Center (CHC)
- ☐ Community Mental Health Clinic
- ☐ Critical Access Hospital-Affiliated Primary Care Clinic
- ☐ Federally Qualified Health Center (FQHC) "Look-Alike"
- ☐ Hospital-Affiliated Primary Care Clinic (Non-Critical Access)
- ☐ My Community Dental Centers
- ☐ Other Not-for-Profit Primary Care Clinic designated as a facility HPSA
- ☐ Private/For-Profit Clinic (Eligible only for NHSC, **not** MSLRP.)
- ☐ Private/Not for Profit Primary Care Clinic
- ☐ State-funded Primary Care Clinic
- ☐ State Psychiatric Hospital
- ☐ State/Federal Correctional Facility
- ☐ Tribal-Affiliated Primary Care Clinic
- ☐ Local Health Department
- ☐ Hospital child/adolescent inpatient psychiatric unit

Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 Months?
Percentage of total practice site caseload that is billed to Medicaid within the past 12 months?

e. Practice Site 3 (If applicable)			
Name of Practice Site:			
Physical Address:			
City:	County:	State:	**9-Digit Zip:**
Number of hours per week that provider will be employed at this site:			
If this practice site is under construction, what is the estimated opening date:			
Practice Site Manager Name:	Practice Site Manager Email:		
Practice Site Manager phone:			

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Check **ALL** of the following that describe the Practice Site:

- ☐ Certified Rural Health Clinic designated as a facility HPSA (CRHC/HPSA See Instructions)
- ☐ Certified Rural Health Clinic not designated as a facility HPSA
- ☐ Community Health Center (CHC)
- ☐ Community Mental Health Clinic
- ☐ Critical Access Hospital-Affiliated Primary Care Clinic
- ☐ Federally Qualified Health Center (FQHC) "Look-Alike"
- ☐ Hospital-Affiliated Primary Care Clinic (Non-Critical Access)
- ☐ My Community Dental Centers
- ☐ Other Not-for-Profit Primary Care Clinic designated as a facility HPSA
- ☐ Private/For-Profit Clinic (Eligible only for NHSC, **not** MSLRP.)
- ☐ Private/Not for Profit Primary Care Clinic
- ☐ State-funded Primary Care Clinic
- ☐ State Psychiatric Hospital
- ☐ State/Federal Correctional Facility
- ☐ Tribal-Affiliated Primary Care Clinic
- ☐ Local Health Department
- ☐ Hospital child/adolescent inpatient psychiatric unit

Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?

Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?

f. Practice Site 4 (If applicable)

Name of Practice Site:

Physical Address:

City:	County:	State:	**9-Digit Zip:**

Number of hours per week that provider will be employed at this site:

If this practice site is under construction, what is the estimated opening date:

Practice Site Manager Name:	Practice Site Manager Email:
Practice Site Manager phone:	

Check **ALL** of the following that describe the Practice Site:

- ☐ Certified Rural Health Clinic designated as a facility HPSA (CRHC/HPSA See Instructions)
- ☐ Certified Rural Health Clinic not designated as a facility HPSA
- ☐ Community Health Center (CHC)
- ☐ Community Mental Health Clinic
- ☐ Critical Access Hospital-Affiliated Primary Care Clinic
- ☐ Federally Qualified Health Center (FQHC) "Look-Alike"
- ☐ Hospital-Affiliated Primary Care Clinic (Non-Critical Access)
- ☐ My Community Dental Centers
- ☐ Other Not-for-Profit Primary Care Clinic designated as a facility HPSA
- ☐ Private/For-Profit Clinic (Eligible only for NHSC, **not** MSLRP.)
- ☐ Private/Not for Profit Primary Care Clinic
- ☐ State-funded Primary Care Clinic
- ☐ State Psychiatric Hospital
- ☐ State/Federal Correctional Facility
- ☐ Tribal-Affiliated Primary Care Clinic
- ☐ Local Health Department
- ☐ Hospital child/adolescent inpatient psychiatric unit

Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?
Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?

g. Practice Site 5 (If applicable)			
Name of Practice Site:			
Physical Address:			
City:	County:	State:	**9-Digit Zip**:
Number of hours per week that provider will be employed at this site:			
If this practice site is under construction, what is the estimated opening date:			
Practice Site Manager Name:	Practice Site Manager Email:		
Practice Site Manager phone:			

Check **ALL** of the following that describe the Practice Site:

- ☐ Certified Rural Health Clinic designated as a facility HPSA (CRHC/HPSA)
- ☐ Certified Rural Health Clinic not designated as a facility HPSA
- ☐ Community Health Center (CHC)
- ☐ Community Mental Health Clinic
- ☐ Critical Access Hospital-Affiliated Primary Care Clinic
- ☐ Federally Qualified Health Center (FQHC) "Look-Alike"
- ☐ Hospital-Affiliated Primary Care Clinic (Non-Critical Access)
- ☐ Michigan Community Dental Clinic
- ☐ Other Not-for-Profit Primary Care Clinic designated as a facility HPSA
- ☐ Private/For-Profit Clinic (Eligible only for NHSC, **not** MSLRP.)
- ☐ Private/Not for Profit Primary Care Clinic
- ☐ State-funded Primary Care Clinic
- ☐ State Psychiatric Hospital
- ☐ State/Federal Correctional Facility
- ☐ Tribal-Affiliated Primary Care Clinic
- ☐ Local Health Department
- ☐ Hospital child/adolescent psychiatric unit

Percentage of total Practice Site caseload that utilizes the Sliding Fee Scale within the last 12 months?
Percentage of total practice site caseload that is billed to Medicaid within the last 12 months?

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Section 4: Certification of Compliance and Declaration of Intent

Certification Statement:
I certify that each of the Practice Sites identified in this application form meet all of the following Michigan State Loan Repayment Program Requirements.

Practice Site Regulations:

The Practice Site(s) identified in this application:

- Are incorporated to do business in Michigan a current and appropriate IRS status as a not-for-profit agency.

- Do not discriminate in the provision of services to an individual because the individual is unable to pay or because payment of those services would be made under Medicare, Medicaid, or the State Children's Health Insurance Program (SHIP), or based upon the individual's race, color, sex, national origin, disability or religion.

- Use a schedule of fees or payments for the site's services that is consistent with locally prevailing rates or charges and is designed to cover the site's reasonable cost of operation,

- Use a discounted/sliding fee schedule to charge for medical services, which is based on federal poverty guidelines and meets National Health Service Corps requirements.

- Have notices posted in a clearly visible location such as the front office or waiting room, and on the site's website (if applicable). The notice explicitly states that no one will be denied access to services due to inability to pay; and there is a discounted/sliding fee schedule available. Sites do not have to post the details of the policy or the actual fee schedule. When applicable, this statement should be translated into the appropriate language/dialect.

- Apply the discounted/sliding fee schedule equally, consistently, and on a continuous basis to all recipients of services, **without regard to the particular clinician that treats them**.

Employment Regulations:

The Sponsoring agency or practice site will not reduce the salary or benefits of MSLRP providers because they receive MSLRP Payments.

For all medical providers, except obstetrician/gynecologist (OB/GYN) physicians, family practice physicians who do provide obstetrics consistently, Certified Nurse Midwives, and inpatient child/adolescent psychiatrists, at least 32 of the minimum 40 hours per week must be spent providing direct primary care clinical services. These services must be conducted during normally scheduled clinic hours in the ambulatory care clinic(s) of the Practice site.

For OB/GYN physicians, family practice physicians who do obstetrics consistently, and Certified Nurse Midwives, at least 21 hours of the minimum 40 hour week must be spent providing clinical services. These services must be conducted during normally scheduled clinic hours in the ambulatory care clinic(s) of the practice site. The remaining hours must be spent providing inpatient care to the patients of that clinic and/or performing practice-related administrative activities, which cannot exceed eight (8) hours of the 40-hour week.

Inpatient, child/adolescent psychiatrists must be employed full-time and provide direct patient care in a hospital, inpatient child/adolescent psychiatric unit.

The required 40 hours per week may be compressed in to not less than four (4) days per week, with no more than 12 hours of work performed in any 24-hour period; inpatient child/adolescent psychiatrists are the only exception to this requirement. Time spent in "on-call" status will not count toward the 40-hour week. Hours worked in excess of 40 hours per week will not be applied to any other workweek.

Michigan State Loan Repayment Program providers can spend no more than seven (7) weeks or 35 workdays per agreement year away from the practice site for vacation, holidays, continuing professional education, illness or any other reason. Absences greater than seven (7) weeks or 35 workdays will extend the service obligation end date. The practice site, or its sponsoring agency, must inform the Michigan State Loan Repayment Program office when a provider goes on extended leave or exceeds the seven (7) week or 35 workday limit.

The practice site will communicate with the Michigan State Loan Repayment Program Office about any changes in practices site or provider employment status, including the provider moving to another practice site, not approved in this application, for any or all of their 40-hour workweek, termination, etc. The practice site will maintain and make available for review by the Michigan Department of Health and Human Services all personnel or other administrative records associated with a Michigan State Loan Repayment Program provider including documentation which contains such information that the Department may need to determine if the provider or practice site have fully complied with the program requirements.

Neither the practice site, nor its sponsoring agency has been investigated for, or convicted of Medicaid or Medicare fraud. If this is not true, please provide a brief explanation of when this occurred and the nature and outcome of the investigation.

Declaration of Intent:

As administrator for the Sponsoring Agency, I affirm our intention to employ the provider who has applied for the Michigan State Loan Repayment Program as identified in this application form throughout any loan agreement they may be awarded. The provider will be employed full time at the practice site(s) identified in this form. The provider will provide direct primary care to an ambulatory setting throughout the term of their Michigan State Loan Repayment Program service obligation. I understand that the provider must spend at least 32 of the minimum 40-hour workweek providing direct primary care clinical services, except for obstetrician/gynecologist physicians, family practice physicians who do obstetrics consistently, certified nurse midwives and inpatient child/adolescent psychiatrists. I also understand that federal program guidelines do not consider services provided in an emergency room/department or trauma center to be primary care services.

If there are any changes in the provider's clinical assignment, practice site locations or employment status, I agree to contact the Michigan State Loan Repayment Program Office within ten (10) working days to inform the office of any of these changes. **I understand that if the sponsoring agency fails to employ the provider throughout the loan repayment period without adequate justification, the sponsoring agency may jeopardize the opportunity to participate in this program in the future.**

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In addition, I agree to read and comply with all policies and procedures described in the P*articipant Information and Requirements* section of the MSLRP website at www.michigan.gov/mslrp.

This Certification of Compliance and Declaration of Intent requires the signature of the administrator identified in Section 1 of this application form. The signature of the administrator below certifies that 1) the information provided in this application form are true and correct; and 2) signifies that the practice site(s) identified comply with the requirements set forth in this application.

_____

Signature **Title** **Date**