Provider Application: Part A

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

Today's Date_________________

1. Personal Information

a. Last Name	b. First Name	c. Middle Name	d. Male Female
e. Home Address:	f. City:	g. State	h. Zip
i. Home Phone:	j. Cell Phone:	k. Direct Work Phone:	
l. Personal Email:	m. Work Email:	n. Additional Email:	
o. Are you a U.S. Citizen? Yes No **PLEASE NOTE: You <u>must be a United States citizen</u> to participate.**	p. Date of Birth:	q. Social Security Number:	
r. Race/Ethnicity: ☐ Hispanic ☐ American Indian, Eskimo or Aleut (AIEA) ☐ White (except Hispanic) ☐ Asian or Pacific Islander (API) ☐ Black (except Hispanic)	s. Are you Multiracial? ☐ Yes ☐ No For the purposes of this question, you are Multiracial if you have parents from more than one of the broad race categories listed or if at least one of your parents is multiracial.	t. If yes, Please mark the races with which you identify ☐ Hispanic ☐ White ☐ Black ☐ API ☐ AIEA ☐ Other	

2. Educational and Professional Information

a. Professional designation ☐ MD ☐ DO ☐ Certified Nurse Mid-wife ☐ Nurse Practitioner ☐ Physician's Assistant ☐ Masters of Social Work (MSW) ☐ DDS/DMD ☐ Psychologist ☐ Counselor		
b. Specialty: ☐ Family Practice ☐ Obstetrics/Gynecology ☐ Pediatrics ☐ Internal Medicine ☐ Mental Health ☐ Geriatrics		
c. License Number:	d. State of Licensure:	e. NPI Number
f. Name of most recent College/University attended:	g. Date started:	h. Graduation date:
i. Name and location of residency program (if applicable)	j. Residency completion date:	

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3. MSLRP Agreement Information

a. Select the statement below that best describes your agreement with your employer regarding employer contributions. My 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.)**

b. 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
- Genesee County Primary Care Providers

c. National Health Service Corps Status

- No – I **have not** applied and **will not** apply to the NHSC Loan Repayment Program (NHSC LRP).
- Yes – I **have** also applied **or will** apply to the NHSC Loan Repayment Program in the upcoming application cycle.

4. Participant Status Information

a. If awarded, will this be your first MSLRP loan repayment agreement? Yes No

If you answered "yes" – skip to section 5. Practice Site Information.
If you answered "no" – continue below. **You MUST provide LRD – see instructions.**

b. Current MSLRP Agreement (if any)

Start Date: End Date: Agreement Amount:

Each 6-month payment dollar amount:
Number of Payments received to date:
Total dollar amount of MSLRP Payments received to date:

c. Most Recently Completed MSLRP Agreement (if any)

Start Date: End Date: Agreement Amount:

d. Next most recently completed MSLRP Agreement

Start Date: End Date: Agreement Amount:

e. Next most recently completed MSLRP Agreement

Start Date: End Date: Agreement Amount:

f. Total dollar amount of payments received from all MSLRP agreements:

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5. Practice Site Information

. **All Providers:** Will you be employed at the practice site(s) listed below for at least 40 hours per week, and for not less than 45 weeks per year? Note that time 'on call' does not count toward 40 hours of employment per week.

Yes No

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at least **32 hours** per week providing direct

Yes No

. **OB/GYN Providers ONLY:** Will you be employed at least 40 hours per week, spending at least **21 hours** per week providing direct primary care in an ambulatory setting during normally scheduled office hours?

Yes No

d. Sponsoring Agency

Name of Sponsoring Agency:			
Address	City	State	Zip

e. Practice Site 1 (Primary Practice Site)

Practice Site Name	Practice Site Type		
Practice Site Address	City	State	**9 Digit-Zip Code**
County:	Date of employment (or Expected date):	Expected Hours Worked Per Week at Site:	

f. Practice Site 2 (if applicable)

Practice Site Name	Practice Site Type		
Practice Site Address	City	State	**9 Digit-Zip Code**
County:	Date of employment (or Expected date):	Expected Hours Worked Per Week at Site:	

g. Practice Site 3 (if applicable)

Practice Site Name	Practice Site Type		
Practice Site Address	City	State	**9 Digit-Zip Code**
County:	Date of employment (or Expected date):	Expected Hours Worked Per Week at Site:	

h. Practice Site 4 (if applicable)

Practice Site Name	Practice Site Type		
Practice Site Address	City	State	**9 Digit-Zip Code**
County:	Date of employment (or Expected date):	Expected Hours Worked Per Week at Site:	

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6. Loan Information

a. Current Loans

#	Account or ID #	Name of Loan Program	Lender	Balance
1				$
2				$
3				$
4				$
5				$
6				$
7				$
8				$
9				$
10				$
11				$
12				$
13				$
14				$
15				$
16				$
17				$
18				$
19				$
20				$
			Total Eligible Debt	**$**

b. Original loans that have been consolidated

Original Loan Name	Current Loan #

➔ Do any of the above loans entail a service obligation requirement, other than for the Michigan State Loan Repayment Program? ☐ Yes ☐ No ***If yes, please circle those loans.***

Certification Statement and Mandatory Signature:

I agree to read and comply with all policies and procedures described in the *Participant Information and Requirements* section of the MSLRP website, as updated annually, and certify that all information in this application is accurate and complete.

____ **Applicant Signature**

________________ **Date**