

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. <input type="checkbox"/> Male <input type="checkbox"/> Female
e. Home Address:		f. City:	g. State:
h. Zip Code:			
i. Home Phone:	j. Cell Phone:	k. Direct Work Phone:	l. Work Phone Ext:
m. Personal Email:	n. Work Email:	o. Additional Email:	
p. Are you a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No PLEASE NOTE: You <u>must be a United States Citizen</u> to participate.	q. Date of Birth:	r. Social Security Number:	
s. Race/Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> American Indian, Eskimo, or Aleut (AIEA) <input type="checkbox"/> White (except Hispanic) <input type="checkbox"/> Asian or Pacific Islander (API) <input type="checkbox"/> Black (except Hispanic)	t. Are you Multiracial? <input type="checkbox"/> Yes <input type="checkbox"/> No <small>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.</small>	u. If yes, Please mark the races with which you identify: <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Black <input type="checkbox"/> API <input type="checkbox"/> AEIA <input type="checkbox"/> Other	
v. Are you from a Rural Residential Background? <input type="checkbox"/> Yes <input type="checkbox"/> No	w. Are you from a Disadvantaged Background? <input type="checkbox"/> Yes <input type="checkbox"/> No	x. Are you a Veteran? <input type="checkbox"/> Yes <input type="checkbox"/> No	

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2. Educational and Professional Information

a. Professional Designation: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> Certified Nurse-Midwife <input type="checkbox"/> Nurse Practitioner <input type="checkbox"/> Physician Assistant <input type="checkbox"/> Masters of Social Work (MSW) <input type="checkbox"/> DDS/DMD <input type="checkbox"/> Psychologist <input type="checkbox"/> Counselor		
b. Specialty: <input type="checkbox"/> Family Practice <input type="checkbox"/> Obstetrics/Gynecology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Mental Health <input type="checkbox"/> Geriatrics <input type="checkbox"/> Psychiatry		
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:
k. Are you currently participating in the Public Service Loan Forgiveness Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Are you currently eligible for loan forgiveness through the Public Service Loan Forgiveness Program? <input type="checkbox"/> Yes <input type="checkbox"/> No	m. If you are participating in the Public Service Loan Forgiveness Program, when will you be eligible for loan forgiveness through the program? (Please list approximate month and year)

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3. MSLRP Agreement Information
<p>a. Select the statement below that best describes your agreement with your employer regarding employer contributions. My employer is:</p> <p style="padding-left: 40px;">Not-for-profit and agrees to contribute 20 percent (20%) of the total amount of any loan repayment agreement I may be awarded.</p> <p style="padding-left: 40px;">Located within Genesee County and agrees to contribute 20 percent (20%) .</p> <p style="padding-left: 40px;">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.</p> <p style="padding-left: 40px;">My employer has not agreed to make employer contributions. (Will be screened out of current application period.)</p>
<p>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):</p> <p style="padding-left: 40px;">Northern Obstetric Service Providers</p> <p style="padding-left: 40px;">Psychiatrist (out-patient, clinic-based)</p> <p style="padding-left: 40px;">Inpatient Pediatric Psychiatrist, Physician Assistant, Nurse Practitioner</p> <p style="padding-left: 40px;">Genesee County Primary Care Providers</p>
<p>c. National Health Service Corps Status</p> <p style="padding-left: 40px;">No – I have not applied and will not apply to the NHSC Loan Repayment Program (NHSC LRP).</p> <p style="padding-left: 40px;">Yes – I have also applied or will apply to the NHSC Loan Repayment Program in the upcoming application cycle.</p>

4. Participant Status Information
<p>a. If awarded, will this be your first MSLRP loan repayment agreement? Yes No</p> <p style="padding-left: 40px;">If you answered “yes” – skip to section 5. Practice Site Information.</p> <p style="padding-left: 40px;">If you answered “no” – continue below. You MUST provide LRD – see instructions.</p>
<p>b. Current MSLRP Agreement (if any)</p> <p style="padding-left: 20px;">Start Date: End Date: Agreement Amount:</p> <p style="padding-left: 40px;">Each 6-month payment dollar amount:</p> <p style="padding-left: 40px;">Number of Payments received to date:</p> <p style="padding-left: 20px;">Total dollar amount of MSLRP Payments received to date:</p>
<p>c. Most Recently Completed MSLRP Agreement (if any)</p> <p style="padding-left: 20px;">Start Date: End Date: Agreement Amount:</p>
<p>d. Next most recently completed MSLRP Agreement</p> <p style="padding-left: 20px;">Start Date: End Date: Agreement Amount:</p>
<p>e. Next most recently completed MSLRP Agreement</p> <p style="padding-left: 20px;">Start Date: End Date: Agreement Amount:</p>
<p>f. Total dollar amount of payments received from all MSLRP agreements:</p>

5. Practice Site Information

a. **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

b. **If you are NOT an OB/GYN Provider:** Will you be employed at least 40 hours per week, spending at least **32 hours** per week providing direct patient care in an ambulatory setting during normally scheduled office hours? Yes No

c. **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
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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:	

i. Practice Site 5 (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:	

