WEST VIRGINIA Department of Health & Human Resources
BUREAU FOR PUBLIC HEALTH

Checklist for State Loan Repayment Program (SLRP) Application:

- ☐ All portions of application are complete (incomplete application will be denied)
- ☐ Copy of citizenship papers are attached if needed
- ☐ Copy of employment contract (if not attached, the application will be denied)
- ☐ Copy of sliding fee schedule (if not attached, the application will be denied)
- ☐ Copy of documentation needed in Student Loan Balance (if not attached, the application will be denied)
- ☐ All signatures are in blue ink

The preferred method of receipt for completed applications with attachments is by e-mail to:

adam.j.kloss@wv.gov

If you submit your application by e-mail and do not receive a return e-mail confirmation within 3 business days, please call the office at 304-352-6018. If no one is available to answer the call, please leave a voice message.

Completed applications with attachments are also accepted by mail to:

State Loan Repayment Program
State Office of Rural Health
WVDHHR/Bureau for Public Health
Office of Community Health Systems and Health Promotion
350 Capitol Street, Room 515
Charleston, West Virginia 25301

Call with Questions: 304-352-6018

INCOMPLETE APPLICATIONS WILL BE RETURNED

APPLICATIONS WILL BE ACCEPTED 3/1/2022 THROUGH 4/30/2022

PERSONAL INFORMATION:

Last Name	First Name	Middle Name

OTHER NAMES USED:

Last Name	First Name	Middle Name

REQUIRED:

Home Telephone	Cell Telephone

DATE OF BIRTH:

Month	Day	Year

CURRENT HOME ADDRESS:

Number	Street	Apt. No.
City	State	Zip Code

EMAIL ADDRESS:

PLACE OF BIRTH:

City	State	Country

ARE YOU A CITIZEN OF THE UNITED STATES? ◯ **YES** ◯ **NO**

(ONLY U.S. CITIZENS OR NATIONALS ARE ELIGIBLE UNDER THIS PROGRAM)

CURRENT EMPLOYER **DATE EMPLOYED**

_____ _____

(Attach a copy of current employment contract)

EMPLOYER FEIN #	**WORK TELEPHONE**
DIRECTOR'S NAME:	**CONTACT'S TELEPHONE**

FACILITY CONTACT EMAIL:

CURRENT WORK ADDRESS:

Number	Street	Apt. No.
City and County	State	Zip Code (include all nine digits)

Type of Provider

- ☐ Allopathic Physician
- ☐ Certified Nurse Midwife
- ☐ Clinical Psychologist
- ☐ Dentist
- ☐ Health Service Psychologist
- ☐ Nurse Practitioner
- ☐ Osteopathic Physician
- ☐ Pharmacist
- ☐ Physician Assistant
- ☐ Psychiatric Nurse Specialist
- ☐ Substance Use Disorder Counselor

Specialties

- ☐ Adult
- ☐ Family Practice
- ☐ Family Practice – Geriatrics
- ☐ Family Practice w/ OB
- ☐ General Practice
- ☐ Geriatrics
- ☐ Internal Medicine
- ☐ Internal Medicine – Geriatrics
- ☐ OB/GYN
- ☐ Pediatrics
- ☐ Psychiatry
- ☐ Psychiatry – Geriatrics
- ☐ Public Health Dentistry
- ☐ Women's Health
- ☐ NONE

AMOUNT OF STUDENT LOAN BALANCE:

(Attach a copy of Loan Balances for Verification)

LANGUAGES KNOWN OTHER THAN ENGLISH:

Read	Write	Speak (Fluently)

DO YOU HAVE AN EXISTING SERVICE OBLIGATION?	○ **YES**	○ **NO**
HAVE YOU HAD A SERVICE OBLIGATION IN THE PAST?	○ **YES**	○ **NO**

IF YES, NAME OF PROGRAM

ADDRESS OF THE PROGRAM

CONTACT PERSON	**CONTACT'S PHONE NUMBER**

TERMS OF OBLIGATION

ARE YOU IN DEFAULT OF THIS OBLIGATION?	○ **YES**	○ **NO**

WHEN WILL THE OBLIGATION BE COMPLETED?

WHEN WILL YOU BE AVAILABLE TO PRACTICE UNDER THE SLRP PROGRAM?

NAME OF PROFESSIONAL SCHOOL FROM WHICH YOU GRADUATED	**DATE OF GRADUATION**
Street **City** **State** **Zip Code**	Month/Day/Year

RESIDENCY OR PROGRAM NAME AND LOCATION

ADDRESS

Street **City** **State** **Zip Code**

ARE YOU BOARD CERTIFIED OR BOARD ELIGIBLE?	○ **YES**	○ **NO**

CREDENTIALS (required before beginning service):

ARE YOU PRESENTLY HOLDING A LICENSE, REGISTRATION, AND/OR CERTIFICATION TO PRACTICE IN WEST VIRGINIA?

○ **YES** ○ **NO** **License #** **NPI #**

INDICATE STATE(S)

NOTE ANY LICENSURE RESTRICTIONS:

STATE OR REGIONAL BOARD:

NATIONAL CERTIFICATION:

PART I AND II NATIONAL BOARDS:

PART III OF NATIONAL BOARDS:

OTHER (Specify)

If additional space is required, please use continuation sheet and type your name at the top of each page and attach to your application.

DO YOU PROVIDE SUD SERVICES?	◯ **YES**	◯ **NO**
DO YOU HAVE A SUD LICENSE OR CERTIFICATION?	◯ **YES**	◯ **NO**
ARE YOU A DATA 2000 WAIVER PROVIDER?	◯ **YES**	◯ **NO**

DESCRIBE YOUR PRACTICE EXPERIENCE OVER THE LAST 5 YEARS.

PERCENT OF PRACTICE TIME:

Office Based **Hospital Based**

Administration **Teaching**

CURRENT STAFFING LEVELS	**QUANTITY**	**FTE EQUIVALENT**
• **Physicians (FP, IM, PED, OB/GYN)**		
• **Nurse Practitioners (FNP, ANP, PNP, OB/GYN, ER**		
• **Physician Assistants (FP, IM, PED, OB/GYN, ER)**		
• **Certified Nurse Midwives**		
PATIENTS BY INSURANCE COVERAGE FOR PAST TWELVE (12) MONTHS		**NUMBER OF PATIENTS**
• **Medicare**		
• **Medicaid**		
• **CHIP**		
• **Insured**		
• **Underinsured**		
• **Uninsured/private pay**		

After fulfilling your WV SLRP service, do you intend to continue practicing your profession in a medically underserved or Health Professional Shortage Area (HPSA)? Please check the appropriate box below.

☐ I do not intend to continue practicing in a HPSA after I have fulfilled my WV SLRP service.

☐ I am undecided as to whether I am going to continue practicing in a HPSA after I have fulfilled by WV SLRP service.

☐ I plan to continue practicing in a HPSA for one or two years after I have fulfilled my WV SLRP service.

☐ I plan to continue practicing in a HPSA for more than two years after I have fulfilled by WV SLRP service.

PROVIDE DOCUMENTATION OF PROFESSIONAL Achievements.

PLEASE PROVIDE A NARRATIVE IN 100 WORDS OR LESS REGARDING YOUR COMMITMENET TO PRACTIVE IN A MEDICALLY UNDERSERVED AREA. If additional space is required, please use continuation sheet and type your name at the top of each page and attach to your application.

PROFESSIONAL REFERENCE INFORMATION (Confidential)

1. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

2. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

3. Reference Name _____

   Position or Title _____ Telephone _____

   Address _____

The following information is voluntary to be used solely to the Program; however, your cooperation is essential for us to ensure adequate evaluation of the State Loan Repayment Program.

_____ **Male** _____ **Female**

Please mark the item below which best describes your primary racial/ethnic background: Please CHECK ALL that are applicable:

- ☐ **Black**
- ☐ **Hispanic**
- ☐ **White**
- ☐ **American Indian or Alaskan Native**
- ☐ **Asian or Pacific Islander**
- ☐ **Other**

CERTIFICATION

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand it may be investigated and that any willfully false representation is sufficient cause for rejection of this application, or, if awarded a Loan Repayment that I am liable for repayment of all awarded funds and, further, that any false statement herein may be punished as a felony.

SIGN YOUR FULL NAME IN BLUE INK

_____ _____

SIGNATURE **DATE**

Print your name with credential initials

FACILITY/EMPLOYER ACCEPTANCE

Candidate's Name

Declarations (Sub-recipient grant agreement will be made in the name of the Employer. Executive Director/DEO must initial each statement.)

- ☐ This grant award will not be used for supplemental income for the Candidate named in this application.
- ☐ The Candidate will provide primary care services a minimum of forty (40) hours a week, forty-five (45) weeks a year, at the practice site listed in this application. Twenty (20) hours a week if award is for part-time work.
- ☐ The Candidate named in this application will practice only at the site(s) listed in this application.
- ☐ Grant funds, if received, will be disbursed to the Candidate's lending institution(s) where medical education loan balance(s) exist within fourteen (14) working days of Employer's receipt of funds from the Department.
- ☐ Within Sixty (60) days of disbursement, Employer will mail a copy of the canceled check or electronic payment to the Department.
- ☐ A copy of the employment agreement between the Employer and the Candidate is enclosed.
- ☐ We will notify the Department immediately upon the departure of the Candidate.

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief and further, that any false statement herein may be punished as a felony. I understand this application may be investigated and that any willfully false representation is sufficient cause for rejection of this application. If our facility is awarded a sub-recipient grant, it is liable for repayment of all awarded funds plus 20% penalty to the Department. It is the responsibility of our facility to recoup funds from the recipient.

Executive Director (or Designee) Signature/Date
Please use blue ink for signature

Please Print Name of Executive Director (or Designee)

Please Print Name of Chief Financial Officer (for Grant Agreement purposes only)

Please Print Email and Phone number for Chief Financial Officer (for Grant Agreement purposed only)