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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF RURAL HEALTH AND PRIMARY CARE, P.O. BOX 570 JEFFERSON CITY, MO 65102

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL STUDENT LOAN REPAYMENT PROGRAM

SECTION 1: APPLICANT'S PERSONAL INFORMATION

APPLICANT'S LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NUMBER

OTHER NAMES USED	DATE OF BIRTH	EMAIL ADDRESS

WORK PHONE NUMBER	CELLULAR PHONE NUMBER	HOME PHONE NUMBER

HOUSEHOLD INCOME FROM MOST RECENT INCOME TAX RETURN (AGI) (INDICATE TAX RETURN YEAR USED)	NO. OF DEPENDENTS

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH	U.S. CITIZEN
	☐ Yes ☐ No

DEMOGRAPHICS: CHECK ALL THAT APPLY *(Award Selections will not be determined by this section)*

GENDER:
☐ Male ☐ Female

ETHNICITY:
☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE:
☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Other: _____

SECTION 2: APPLICANT'S EMPLOYMENT INFORMATION

EMPLOYER

STREET ADDRESS	CITY	STATE	ZIP CODE	COUNTY

WORK TELEPHONE & EXTENSION	WORK EMAIL

FACILITY SITE ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE	COUNTY

SUPERVISOR'S NAME	SUPERVISOR'S WORK TELEPHONE & EXTENSION	SUPERVISOR'S WORK EMAIL

APPLICANT'S TITLE	DATE EMPLOYED	THIS FACILITY IS
		☐ Public ☐ Private ☐ Non-Profit ☐ For-Profit

TOTAL HOURS WORKED PER WEEK	DIRECT PATIENT CARE HOURS PER WEEK	DO YOU SEE PATIENTS REGARDLESS OF ABILITY TO PAY?
		☐ Yes ☐ No

SECTION 3: APPLICANT'S SCHOOL / RESIDENCY PROGRAM INFORMATION

LAST SCHOOL ATTENDED	RESIDENCY PROGRAM (IF APPLICABLE)	DATE OF COMPLETION (MM/DD/YYYY)

OF THE LIST BELOW, INDICATE THE DEGREE EARNED

DOCTOR OF ALLOPATHIC MEDICINE (MD)
☐ OB/GYN ☐ Internal Medicine ☐ Family Medicine
☐ Pediatrics ☐ Psychiatry

DOCTOR OF OSTEOPATHIC MEDICINE (DO)
☐ OB/GYN ☐ Internal Medicine ☐ Family Medicine
☐ Pediatrics ☐ Psychiatry

DOCTOR OF DENTISTRY
☐ Doctor of Dental Surgery (DDS) ☐ Doctor of Medicine in Dentistry (DMD)

SECTION 4: ADDITIONAL INFORMATION *(REQUIRED TO BE REPORTED BUT NOT USED FOR AWARD SELECTION)*

SUBSTANCE USE DISORDER (SUD) AND TELEHEALTH QUESTIONS *(This information is collected for reporting purposes)*

DO YOU PROVIDE SUD SERVICES?	DO YOU HAVE A SUD LICENSE OR CERTIFICATE ISSUED BY THE STATE OR NATIONAL CREDITING AGENCY?
☐ Yes ☐ No	☐ Yes ☐ No

DO YOU HAVE SPECIFIC TRAINING & CREDENTIALS TO PROVIDE EVIDENCE-BASED SUD TREATMENT?
☐ Yes ☐ No

DO YOU PROVIDE
☐ Bupernorphine ☐ Counseling ☐ Both ☐ Neither

DO YOU POSSESS A DATA 2000 WAIVER?	IF YES, WHICH PANEL SIZE?
☐ Yes ☐ No	☐ DW30 ☐ DW100 ☐ DW275

ARE YOU A TELEHEALTH PROVIDER?	IF YES, STATE APPROXIMATE HOURS PER WEEK ENGAGED IN TELEHEALTH
☐ Yes ☐ No	_____

SECTION 4: ADDITIONAL INFORMATION CONTINUED

APPLICANT'S EMPLOYMENT HISTORY IN UNDERSERVED AREAS *(This information is collected for reporting purposes)*

HOW MANY YEARS HAVE YOU PROVIDED HEALTH CARE SERVICES IN A HPSA / RURAL AREA?	HOW MANY ADDITIONAL YEARS DO YOU PLAN TO CONTINUE WORKING IN A HPSA / RURAL AREA?

PLEASE LIST ALL EMPLOYMENT WORKING IN A HEALTH PROFESSIONAL SHORTAGE AREA (HSPA / RURAL AREA)

County: _____ No. of Years Served: _____

☐ Part-Time ☐ Full-Time

Employer Name and Job Title: _____

County: _____ No. of Years Served: _____

☐ Part-Time ☐ Full-Time

Employer Name and Job Title: _____

County: _____ No. of Years Served: _____

☐ Part-Time ☐ Full-Time

Employer Name and Job Title: _____

County: _____ No. of Years Served: _____

☐ Part-Time ☐ Full-Time

Employer Name and Job Title: _____

SECTION 5: PROVIDER BILLING VERIFICATION

ANSWER ALL THAT ARE APPLICABLE TO YOUR PROFESSION

NATIONAL PROVIDER (NPI) NUMBER	MEDICAID BILLING NPI

DO YOU ACCEPT MEDICAID FEE-FOR-SERVICE (FFS)? — BILLING NPI NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

DO YOU ACCEPT MEDICAID HOME STATE HEALTH / OR CURRENT REPLACEMENT PLAN? — BILLING NPI NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

IDENTIFY REPLACEMENT PLAN

DO YOU ACCEPT MEDICAID MISSOURI CARE / OR CURRENT REPLACEMENT PLAN? — BILLING NPI NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

IDENTIFY REPLACEMENT PLAN

DO YOU ACCEPT MEDICAID UNITED HEALTH CARE / OR CURRENT REPLACEMENT PLAN? — BILLING NPI NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

IDENTIFY REPLACEMENT PLAN

MEDICARE PROVIDER TRANSACTION ACCESS NUMBER (PTAN)

DO YOU ACCEPT MEDICARE FFS? — BILLING NPI / PTAN NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

DO YOU ACCEPT ALL MEDICARE ADVANTAGE / PART C PLANS? — BILLING NPI / PTAN NUMBER

☐ Yes ☐ No ☐ N/A

If No or N/A, Explain:_____

ARE YOU CURRENTLY ENROLLED IN ANY OTHER MEDICARE PLANS?

☐ Yes ☐ No If Yes, Specify: _____

PROFESSIONAL LICENSE NUMBER	ARE YOU A BOARD CERTIFIED PHYSICIAN? ☐ Yes ☐ No	BOARD CERTIFICATION NUMBER

LIST ANY OTHER STATES IN WHICH YOU ARE LICENSED TO PRACTICE AND YOUR LICENSE NUMBER(S)

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SECTION 6: EDUCATIONAL DEBT INFORMATION

DO YOU HAVE AN EXISTING SERVICE OBLIGATION, SUCH AS NHSC? ☐ Yes ☐ No If Yes, Date to be Completed: _____

ARE YOU IN DEFAULT OF THIS OBLIGATION? ☐ Yes ☐ No

NAME OF PROGRAM	CONTACT NAME	CONTACT PHONE

HAVE YOU EVER DEFAULTED ON A STATE OR FEDERAL LOAN? ☐ Yes ☐ No If Yes, list the name of the loan, type of loan, and reason for default: _____

***ATTACH A COPY OF YOUR MOST RECENT CREDIT REPORT**

ONLY INCLUDE ELIGIBLE DEBTS IN THE TABLE BELOW

LENDING INSTITUTION NAME	ACCOUNT NUMBER	BALANCE	PHONE NUMBER
	TOTAL:	$ 0.00	

APPLICATIONS SUBMITTED WITHOUT THE SUPPLEMENTAL REQUIRED DOCUMENTATION WILL NOT BE PROCESSED. (REFER TO SECTION 7: REQUIRED SUPPLEMENTAL DOCUMENTATION)

SECTION 7: REQUIRED SUPPLEMENTAL DOCUMENTATION

HAVE YOU ENCLOSED? *****REVIEW APPLICATION INSTRUCTIONS FOR FURTHER DETAIL*****

- ☐ A copy of your employment contract for the proposed practice site for a period of no less than two (2) years.
- ☐ A copy of your professional license
- ☐ Proof of malpractice insurance
- ☐ A copy of the payer mix percentage report
- ☐ A copy of the sliding fee scale
- ☐ Proof of qualifying, outstanding educational debt
- ☐ A letter of support/recommendation from your employer or a copy of your latest performance appraisal
- ☐ A copy of your official job description(s)
- ☐ A list of services provided by your employer
- ☐ A copy of your most recent credit report

The undersigned hereby authorized the full disclosure of any information regarding the nature, amount, terms and status of this loan for the purpose of entering an agreement with the Missouri Department of Health and Senior Services for repayment of said loans.

The undersigned hereby certifies the accuracy of the information in the application and applies to enter into an agreement with the Missouri Department of Health and Senior Services for repayment of a portion of the educational loans listed above.

PRINT FULL NAME

SIGNATURE | DATE

MAILING ADDRESS

Missouri Department of Health and Senior Services
Office of Rural Health and Primary Care
MO Professional Student Loan Repayment Program
P.O. Box 570
Jefferson City, MO 65102-0570