REQUIRED SUPPORTING DOCUMENTATION FOR THE NEW STATE LOAN REPAYMENT (SLRP) APPLICATION

No application will be considered unless all questionnaires are completed and supporting documents are submitted in a timely manner. "Received Date" is a level of priority; applications will not be considered received until they are complete.

- **Provide current resume (1 copy)**
  - Must have current employer and practice site(s) listed.
- **Copy of most recent Licensure, showing the expiration date (1 copy).**
- **Proof of citizenship or naturalization (1 copy)**
  - Acceptable documentation: Birth Certificate, Baptismal certificate, hospital birth records, US Passport, Alien Registration Card, Naturalization Certificate, any form of work eligibility documentation defined by USCIS, Native American Tribal Documents, DD Form 214
- **Copies of all outstanding medical, behavioral, and/or dental educational loan balances**

- It is also important you read and understand the certification statement at the end of your application before you sign and notarize.
- Applications must be received in paper form via mail (you may scan/email a **complete**, notarized copy as well) and:

  • **Applications should be printed single-sided.**

  • **Do not use staples, binders, or pages larger or smaller than 8.5 x 11.**

- **Please return the completed application to:**

Virgin Islands Department of Health

ATTN: Renise James, Director

4006 Estate Diamond, Suite 104

Christiansted, VI 00820

You may email a COMPLETE scanned copy to: renise.james@doh.vi.gov

If you have any questions, please e-mail **renise.james@doh.vi.gov**

To learn more about the State Loan Repayment Program you may go to our website at:

http://www.doh.gov

U.S. VIRGIN ISLANDS STATE LOAN REPAYMENT PROGRAM
APPLICATION Applicant Questionnaire

- Loan Repayment Agreement Terms begin July 1st, October 1st, January 1st, and April 1st during the State's fiscal year (July 1st through June 30th). The first payment is paid in the first month of the following quarter, and quarterly thereafter for the duration of the contract. Applicants are responsible for submitting complete applications. Application packages will be initially reviewed to determine their completeness. Application packages deemed incomplete as of the application deadline will not be considered for funding for that contract term.

START HERE - Please type or print in blue ink.

Name: _____
Last First Middle

Mailing Address: _____

City:_____ State:_____ Zip:_____

Home Phone: _____Cell: _____Preferred/Work E-mail:_____

Work Phone: _____Work Fax: _____Secondary/Work Email:_____

National Provider Identifier (NPI): _____Sex: Male ☐ Female ☐

DOB: _____

- U.S. Citizen or U.S. National? ☐YES ☐NO ☐
- Please check your discipline:

Tier 1	Tier 2	Tier 3
☐ MD	☐ PA	☐ RDH
☐ DO	☐ PA-Hospitalist	☐ LADC
☐ General Surgeon	☐ APRN	☐ Primary Care (only) RN
☐ MD/ DO-Hospital	☐ APRN-Hospitalist	
☐ Psychiatrist	☐ CNM	
☐ DMD	☐ PsyD	
☐ DDS	☐ Psych NP	
	☐ MHC	
	☐ CSW	
	☐ MFT	
	☐ MILADC	
	☐ Behavioral Health under supervision	

- Are you licensed in USVI? ☐YES ☐NO
  If not, when do you plan to receive your license (or approximate)? (month/year) _____/_____
- Length of employment at current facility: Years: _____Months: _____Salary/Wage: _____

If unemployed, beginning date of new employment (month/day/year): _____
Salary/Wage: _____

- Are you currently working for an eligible Department of Health and Human Services-funded program? ☐ Yes ☐No
  If yes, please provide the name of the program: _____
- Are you considered: ☐Full-Time ☐Part-Time (SLRP determines whether your status for your contract will be F/T or P/T.)
- Maximum hours do you work in a week? _____
- Maximum hours that you work in a week providing **outpatient** direct patient care: _____
- Maximum hours providing clinical services in alternative settings (e.g., hospitals, schools, shelters): _____
- Maximum hours that you work in a week providing administrative duties: _____
- How many days per week do you work? _____
- How many hours per day do you work in a regular week? _____
- Hours spent teaching or on research during a regular work week: _____
- Do you speak another language other than English in your clinical practice? ☐YES ☐NO If yes,

☐ French	☐Chinese	☐Hindi	☐Arabic
☐ Spanish	☐German	☐Italian	☐American Sign Language
☐ Portuguese	☐Greek	☐Russian	☐Other _____

The practice site is located in which federally designed shortage area? (check one) ☐HPSA ☐MHPSA

☐ DHPSA ☐MUP☐ EMUP ☐Non-designated

Appendix A. You will find out whether your practice site is in a federally designated shortage area:

Primary Practice Site:_____

Site Address: _____

City: _____State: _____Zip: _____County: _____

Work Phone: _____Fax #: _____

Hours spent in outpatient direct patient care: _____

Hours spent in clinical services at an alternating setting: _____

Hours spent in administration: _____

Secondary Practice Site:_____

Site Address: _____

City: _____State: _____Zip: _____County: _____

Work Phone: _____Fax #: _____

Hours spent in outpatient direct patient care: _____

Hours spent in clinical services at an alternating setting: _____

Hours spent in administration: _____

Name of Employer if different from Primary Practice Site:_____

Employer Address:_____

City: _____State: _____Zip: _____County: _____

Work Phone: _____Fax #: _____

Manager/Representative for Application process and quarterly reports:_____Title: _____

Phone #: _____E-mail:_____

(This person will be the contact for quarterly verifications by the State to determine provider contract compliance.)

- Do you agree to charge for services at the usual and customary rates prevailing in the primary care service area, with the exception of patients unable to pay the usual and customary rates who shall be charged – according to the service site's sliding fee schedule and based on poverty level - a reduced rate or no charge at all?☐ YES ☐NO
- Do you agree not to discriminate on the patient's ability to pay for care or the payment source, including Medicare and Medicaid? ☐YES ☐NO
- Do you have any outstanding contractual obligations for health services to the:
    - Active Military? ☐YES☐ NO
    - National Guard? ☐YES ☐NO
    - National Health Service Corps Loan Repayment Program (NHSC LRP)? ☐YES ☐NO
    - NHSC Scholarship Program? ☐YES ☐NO
    - Nurse Education Loan Repayment Program (NELRP)? ☐YES ☐NO
    - Nursing Scholarship Program? ☐YES ☐NO
    - State or other entity? ☐YES ☐NO

If yes to any above, when will the service obligation be completely satisfied?_____

Answering yes to any of the questions below requires that an **explanation be attached** to the application.

- Do you have a judgment lien against your property for a debt to the United States? ☐YES ☐NO
- Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? ☐YES ☐NO
- Has your medical/certification license ever been suspended or revoked in any state? ☐YES ☐NO

If yes, when? _____

Reason for suspension/revocation:_____

- Are any professional disciplinary actions against you pending in any state? ☐YES ☐NO

If yes, date of disciplinary action (month/year): _____/_____

Reason:_____

- Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws? ☐YES ☐NO
- Do you have a judgment lien against your property for a debt to the United States? ☐YES ☐NO
- Are you delinquent in childcare payments in any State? ☐YES ☐NO

If yes, please explain: _____

LOAN EXPENSES FOR MEDICAL PROFESSIONAL EDUCATION THAT ARE OUTSTANDING

*Attach copies of all outstanding medical and/or dental educational loan balances from the month previous to, or the month of, this application. Copies of education loan balances not received will not be considered. Please be especially diligent when completing this section, filling in each loan and then the total of the loans. Those marked "Attached" will be deemed incomplete causing delay.

Lender Name	Account#	Original Amt. of Loan	Current Balance Due	Balance Due Date	Monthly Payment
	Total				

The amount you are requesting from the State Loan Repayment Program: $_____

Note: Please provide this information to your employer so that they know what amount of matching funds might be needed. See information on the website for possible loan repayments for part- and full-time health care providers.

If your service site is located in a Health Professional Shortage Area (HPSA), Mental Health Shortage Area (MHPSA), or Dental Health Shortage Area (DHPSA) in USVI, have you applied for federal loan repayment (should be done before State Loan Repayment) for this year? ☐YES ☐NO If yes, was it approved? ☐YES ☐NO Pending Decision (If "pending" you must wait until a decision is received to apply for SLRP. If denied, please provide a copy of the notification from NHSC.)

- Where did you hear about the State Loan Repayment Program?

☐ School ☐Employer ☐Co-Worker ☐Internet ☐State website ☐Other_____

CERTIFICATION BY APPLICANT

(Notary Required)

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I understand that the information I have provided is subject to verification and that willfully providing false information may result in immediate disqualification from participation in this program. Any person who knowingly makes a false statement or misrepresentation in this loan application repayment transaction, fraudulently obtains repayment for a loan, or commits any other legal action in connection with this transaction is subject to repaying any amount received from this program, plus interest. Once an agreement is signed, any person who, through the legal agreement, commits to serve and fails to complete the period of obligated services shall be liable to the U.S.V.I Department of Health for an amount equal to the sum of the total amount paid to them under the agreement as well as an unserved obligation penalty in an amount equal to 20% of the total agreement amount paid out. S/he shall also forfeit any remaining allotments under that agreement. This entails making a legal commitment to serve for three years (or two years part-time) at the stated practice site. I have read this statement and understand its contents.

Applicant Signature: _____ Date: _____

Must be signed on the date of notarization.

Witness:_____ Date: _____

Notary Public or Justice of the Peace

SEAL