OHIO LOAN REPAYMENT PROGRAM APPLICATION

Ohio Dental Hygienist Loan Repayment Program
Ohio Dentist Loan Repayment Program
Ohio Physician Loan Repayment Program
State Loan Repayment Program

Date Application Received by ODH

I. Applicant Information

Name

Last First MI Maiden

Home Phone

Home Address

Cell Phone

City State Zip+4

E-mail

Home County Place of Birth

Date of Birth

Race *(select all that apply)*

- ☐ White
- ☐ Black or African American
- ☐ American Indian/Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian/Other Pacific Islander
- ☐ Other

Ethnicity *(select only one)*

- ☐ Hispanic, Latino or Spanish Origin
- ☐ Not Hispanic, Latino or Spanish Origin

Languages Spoken *(other than English)*

Geographic Background

City	State	Rural	Inner City	Appalachian	Other	Ages
		☐	☐	☐	☐	to
		☐	☐	☐	☐	to
		☐	☐	☐	☐	to

U.S. residency status

- ☐ U.S. Citizen
- ☐ U.S. National
- ☐ Legal Alien
- ☐ Other

Physicians:
DATA 2000 Waiver
☐ Yes ☐ No

Are you a veteran of the U.S. Armed Forces?
Yes ☐ ☐ No

Ohio License Number

Ohio Medicaid Number *(if applicable)*

Discipline
Physician ☐ Dentist ☐ Registered Dental Hygienist ☐ Other ☐

National Provider Identifier (NPI) *(if applicable)*

Specialty *(select all that apply)*

- ☐ Adolescent Medicine
- ☐ Child/Adolescent Psych
- ☐ Family Practice
- ☐ General Psych
- ☐ General IM
- ☐ Geriatric Psych
- ☐ Geriatrics
- ☐ GPR/AEGD
- ☐ IM/PEDS
- ☐ OB/GYN
- ☐ Pediatrics
- ☐ Other

Current employment contract *(if applicable)*

Start Date:

End Date:

If in residency training, date available to practice

II. Education and Credentials

Health professions school/training program: City/State:

Dates of Attendance: through Date of graduation

Residency Program: City/State:

Dates of Attendance: through Date of graduation:

Any additional training programs: City/State:

Dates of Attendance: through Date of completion:

Current Status *(select one)*	Credentials *(required before beginning the program)*
☐ Enrolled in final year of training program or residency ☐ Practicing in Ohio ☐ Practicing outside of Ohio ☐ Not currently in practice	List State(s) where you currently hold a license or certification:
Are you Board certified or eligible? ☐ Yes ☐ No ☐ Pending ☐ N/A	Note any licensure restrictions *(if applicable)*

III. Obligations

Note: All applicants who have an outstanding contractual obligation for health professional service to the Federal Government (e.g., an active military obligation), a State (e.g., Loan Repayment, Scholarship) or other entity are ineligible to participate in Ohio's health professional loan repayment programs unless that service obligation will be completely satisfied before a loan repayment contract with the state of Ohio begins. Be aware that certain clauses in employment contracts may impose a service obligation. See application instructions for additional information.

A. Did you apply to the National Health Service Corps Loan Repayment Program this year? ☐ Yes ☐ No

B. Do you have a Primary Care Loan from the Health Resources and Services Administration through your medical school? ☐ Yes ☐ No

C. Are you a member of a Reserve Component of the Armed Forces or National Guard? ☐ Yes ☐ No

D. Do you have an existing service obligation? *Please include information about Choose Ohio First Scholarship and MEDTAPP programs through your health professions training programs.* ☐ Yes* ☐ No

**If yes, please complete the following:*

Name/Description of obligation

Contact person: Telephone: Completion date:

Terms of obligation:

Are you in default on this obligation? ☐ Yes ☐ No

IV. Background and Biographical Statements

On a separate document, respond to all of the following requests. Label each section to correspond with the letters and numbers below:

A. Describe your and your spouse's/partner's geographic background. Include the names of your hometowns, what it was like growing up there, and any time spent in Appalachian, rural or inner city communities.

B. Describe your experience with underserved and diverse populations. Include student, volunteer and work experiences and detail the following information for each experience:

1) Name of program, if applicable, and whether the experience was required for school/training;
2) Year and length of experience, including average time commitment per week;
3) Location of experience and brief description of services provided;
4) Knowledge, skills and abilities gained from the experience; and
5) Results of experience (e.g., development of community programs, awards, published articles, etc.).

C. Provide two to four professional goals related to your practice in an underserved area.

D. Describe your and your family's interest in living and working in an underserved area.

E. Share language skills, including level of proficiency (if any), that you use or will use to provide services to the patient population of the practice site.

F. List any experience you have with National Health Service Corps programs (SEARCH, Scholarship or Loan Repayment).

G. Provide any additional knowledge, skills and abilities that will be incorporated into your practice to improve the delivery of health services to the population of the community where the practice site is located. Consider the values, beliefs and practices of the patient population.

V. Certification and Acknowledgement

A. I certify that the information given in the application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for the rejection of this application.

_____

Applicant's signature Date

B. I acknowledge that I have read the Application Information and understand that if selected for a loan repayment contract, I will be obligated to remain at the practice site(s) for a minimum of two years. I also understand that failure to uphold the requirements of a loan repayment contract could result in significant financial consequences.

_____

Applicant's signature Date

VI. Loan Information

Directions: Please list all loans for which you currently have an outstanding balance and are requesting to be paid by this program. For each loan listed in Section B below, attach a copy of the loan agreement and a current statement from the lender showing the balance.

A. Applicant Information

Name (Last, First, MI) E-Mail Address

Home Address

City State Zip Telephone Number

Have you consolidated your loans *for undergraduate costs* with health professions training program loans? ☐ Yes* ☐ No

*If Yes, attach a copy of the loan documents which reflect the new consolidated loan.

Have you consolidated your loans *with another person*? ☐ Yes** ☐ No

**If Yes, with whom?

Attach copies of the loan documents from both parties which reflect the new consolidated loan.

B. Lender Information

This program pays for the educational costs for the discipline listed in Section I of the Application. If loans have been consolidated, a determination will be made of the proportion of the consolidation loan that will be paid for a successful applicant. Only institutional or government loans are eligible for repayment, including Stafford, SLS, HEAL, Perkins, and others. Loans from individuals are not eligible.

AWARD YEAR	DISBURSEMENT DATE	LOAN HOLDER/SERVICER	ORIGINAL LOAN AMOUNT	CURRENT BALANCE	DATE OF BALANCE
		TOTALS	$ 0.00	$ 0.00	

Are any parts of the loan(s) listed above being paid by another organization? ☐ Yes* ☐ No

*If yes, specify the amount being paid for applicable loans, the name of the organization and the terms, including any obligation by the applicant.

Amount Payer

Terms

C. Certification

I certify that the information given about my professional training loans is accurate and complete to the best of my knowledge and belief. I understand that the information provided may be investigated and that any false representation is sufficient cause for rejection of this application.

Signature _____ Date