Department of Health

Ohio Substance Use Disorder Professional Loan Repayment Program

Ohio Application Guidance and Instructions

Ohio Department of Health
Primary Care Office (PCO)
246 North High Street
Columbus, Ohio 43215

Background

The Ohio Substance Use Disorder Professional Loan Repayment Program (Ohio SUDLRP) is administered by the Primary Care Office within the Ohio Department of Health (ODH). The Ohio SUDLRP seeks substance use disorder (SUD) treatment providers to provide culturally competent, interdisciplinary SUD treatment services to underserved populations located in selected health professional shortage areas (HPSAs) and/or in other high-burdened SUD areas of the state. In return, the Ohio SUDLRP assists clinicians in their repayment of outstanding ***qualifying*** educational loans.

The Ohio SUDLRP seeks clinicians who demonstrate the characteristics for, and an interest in, treating the state's underserved populations and remaining in HPSAs, or other areas of need beyond their service commitment. It is important to remember that treatment to underserved populations and vulnerable populations, not the repayment of educational loans, is the primary purpose of the Ohio SUDLRP.

Eligibility

The following disciplines are eligible to apply:

Licensed independent chemical dependency counselor (LICDC). Licensed independent social worker (LISW).
Licensed independent marriage and family therapist (LIMFT). Licensed professional clinical counselor (LPCC).
Clinical or counseling psychologist (PsyD/PhD).
Physician (DO/MD).
Physician assistant (PA).
Nurse practitioner (NP).
Clinical nurse specialist (CNS).
Certified nurse midwife (CNM).
Pharmacist (RPh).
Registered Nurse (RN).

Applicants may work full-time, defined as a ***minimum*** of 40 hours per week at an eligible site, or part-time, defined as ***at least*** 20 hours per week but no more than 39 hours per week.

Full-time practitioners must spend a ***minimum*** of 32 hours per week providing direct client care at the approved practice site(s). A ***minimum*** of 50% of that time (16 hours) must be spent providing SUD treatment. The remaining eight hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s).

Part-time practitioners must spend a ***minimum*** of 16 hours per week providing direct client care at the approved practice sites(s). A ***minimum*** of 50% of that time (eight hours) must be spent providing SUD treatment. The remaining four hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s).

Teaching may be considered part of the direct client care hours under certain circumstances. To qualify as clinical practice, teaching must occur at the approved practice site.

Telemedicine may be considered part of the direct client care hours under certain circumstances. Telemedicine must be furnished using interactive telecommunication equipment that provides real time two-way communication between the client and the provider. The originating site (client location) and the provider site must both meet the site eligibility requirements.

Preference will be given to providers being recruited or retained to practice at sites that offer services on a sliding fee scale based on 200% of the federal poverty level, and are located in or designated as mental health HPSAs. ***See page 10 for more HPSA information.***

Application and Due Date

The application consists of the ***Ohio Department of Health Application for Loan Repayment, Employer Agreement, Practice Site Summary, and all other required documents as listed below***. All application documentsmust be completed electronically for submission. Submissions must be in the form of a PDF file. Apart from lobby photos (see below), photos of application documents may not be reviewed. Applications and supporting documents must be received via email. Email completed application with supporting documentation to PCRH@odh.ohio.gov.

Please note: ***Incomplete or late applications may not be reviewed.***

RequiredDocuments

The applicant must submit the following documents:

1. Ohio Substance Use Disorder Professional Loan Repayment Program Application.
2. Qualifying student loan balance statements from all lenders for which applicant is requesting payment (statements must show practitioner's name, current loan balance and account number). **In addition, please submit loan information from the National Student Loan Data System (NSLDS).** Instructions for accessing this website can be found in the Frequently Asked Questions section (see page 9).
3. Employer Agreement* [must be completed by the applicant's employer(s), one per employer].
4. Practice Site Summary* [one for each practice site where the applicant will provide services, completed by applicant's employer].
5. Sliding fee scale (SFS) and/or financial assistance documents used at the practice site.
6. Lobby photo: photo of the signage stating "no person will be denied care based upon an inability to pay for the services" that is displayed in the registration/waiting area of the practice site.
7. Current résumé or curriculum vitae.
8. Current Ohio professional license^ (copy).
9. Background and Biographical Statement narrative (refer to Section IV of the application).
10. Signed position/job description.
11. Employment contract – if applicable.

***Please note:** Employer Agreement (#3) and Practice Site Summary (#4) must be completed by the applicant's employer and/or practice site administrator, unless the applicant is the practice owner.

*Application forms are available at the PCO website: Ohio Primary Care Office Workforce Programs.

^If awarded, applicants with pending licenses must submit verification of licensure prior to receiving a loan repayment contract.

Application Instructions

OHIO SUBSTANCE USE DISORDER PROFESSIONAL LOAN REPAYMENT PROGRAM APPLICATION

I. Applicant Information

- Complete all sections unless the field is not applicable to your specific circumstances. Enter your home address in the first section. More than one option may be selected for ó Race;ô choose only one option for ó Ethnicity.ô If you have resided in multiple geographic area types (i.e., rural, urban, etc.), list up to three areas where you have lived the most years; include ages while living there. ó Otherô includes suburban, adequately served areas in the city, etc.
- **Apply for an OH/ID-Supplier ID number at https://supplier.ohio.gov before beginning your application to allow for processing time. Contact Ohio Shared Services at 1-877-644-6771 for assistance.**

II. Education and Credentials

- Respond to all components, including dates of attendance and graduation. List only the graduate/professional training/ educational program(s) from which you graduated that led to your eligible discipline.

III. Obligations

- Individuals with an existing service obligation are not eligible for the Substance Use Disorder Professional Loan Repayment Program ***unless*** the obligation will be fulfilled prior to beginning the Ohio loan repayment contract. This includes loan repayment programs in other states; National Health Service Corps Loan Repayment, Scholarship, or Students to Service Programs; Ohioõs MEDTAPP program; Choose Ohio First Scholarship Program; active military obligations; or employment contracts/agreements that provide loan repayment or impose a service obligation.

IV. Background and Biographical Statements

- In narrative form, please respond to all seven items listed in Section IV of the application in the order they appear. Type all responses on a separate document and include with the completed application packet.

V. Certification and Acknowledgement

- Applicant must sign and date both Sections A and B.

VI. Loan Information

- **SECTION A: Applicant Information**

  If you have consolidated health professional training/educational school loans with other non-health related professional training/educational school loans, include all original loan documents, as well as the consolidation documents. If loans were consolidated with another person, attach a copy of loan documents from both parties reflecting the new consolidated loan.

- **SECTION B: Lender Information**

  In the table provided, enter each loan for which you are requesting repayment (attach additional pages, as needed). A current balance statement from ***each*** loan holder/servicer must be included with the application. Include loan information from the National Student Loan Data System (see page 9).

  ***Please note that if you have defaulted on any student loan obligation, you may not be eligible for the Ohio loan repayment program.**

- **SECTION C: Certification**

  Print the completed form, then sign and date Section VI, Loan Information, of the Loan Repayment Application after all sections are complete.

Employer Agreement document:

- This form must be completed by the employer unless the applicant owns the practice. If you are employed by more than one employer, use a second Employer Agreement form for information regarding the additional employer(s).
- Complete the agreement electronically, then print and sign. Signed agreement must be included with the Ohio Substance Use Disorder Professional Loan Repayment Application.

Practice Site Summary document:

- The applicant's employer(s) must complete one Practice Site Summary form for each practice site where the applicant is/or will be practicing. All sections must be completed in their entirety, including information about the employer. The office manager, billing manager or similar staff member must complete the Practice Site Summary form. The applicant ***cannot*** complete the Practice Site Summary unless he or she is the practice owner.
- All fields are required, including the certification at the bottom of the page. The form is electronically fillable, but once completed, the form must be printed and signed, then submitted with the applicant's Ohio Substance Use Disorder Professional Loan Repayment Program Application.

Submission Instructions:

The application consists of the ***Ohio Department of Health Application for Loan Repayment, Employer Agreement, Practice Site Summary, and all other required documents as listed below.*** All application documents must be completed electronically for submission. Submissions must be in the form of a PDF file. Apart from lobby photos (see below), photos of application documents may not be reviewed. Applications and supporting documents must be received via email.

Email completed application with supporting documentation to PCRH@odh.ohio.gov.

Submission Checklist:

- ☐ Application.
- ☐ Employer Agreement (one per employer).
- ☐ Practice Site Summary (complete one per practice site).
- ☐ Background and Biographical Statements narrative.
- ☐ Qualifying loan balance statements (one per loan requested for repayment).
- ☐ Original loan documents, if health professional training/educational loans were consolidated with non-health professional training/educational loans, or if consolidated with another person's loans.
- ☐ Résumé or curriculum vitae.
- ☐ Copy of current Ohio professional license.
- ☐ Sliding fee scale and/or financial assistance documents used at practice site(s).
- ☐ Photo of the practice site's lobby/registration area sign stating no person will be denied care based upon an inability to pay for the services.
- ☐ Signed position/job description.
- ☐ Copy of employment contract , if applicable.

FREQUENTLY ASKED QUESTIONS

1. **What is the purpose of Ohio's loan repayment programs?**
   Loan repayment programs for certain health care professionals were created to assist communities and practice sites located in underserved areas of Ohio to recruit primary care, dental, and/or behavioral health professionals to provide services to the residents of the area. In addition, the programs assist primary care physicians, behavioral health providers, and dental professionals who are dedicated to working with the underserved in Ohio to repay qualifying health professional training/educational loans. Retention of providers in the underserved community is the primary goal of the programs.

2. **Who is eligible to apply for loan repayment?**
   The following disciplines are eligible to apply to the Ohio SUDLRP:

   - Licensed independent chemical dependency counselor (LICDC).
   - Licensed independent social worker (LISW).
   - Licensed independent marriage and family therapist (LIMFT). Licensed professional clinical counselor (LPCC).
   - Clinical or counseling psychologist (PsyD/PhD).
   - Physician (DO/MD).
   - Physician assistant (PA).
   - Nurse practitioner (NP).
   - Clinical nurse specialist (CNS).
   - Certified nurse midwife (CNM).
   - Pharmacist (RPh).
   - Registered nurse (RN).

   If an applicant has an existing obligation to a government, or other entity (including your employer), the obligation must be met prior to beginning a loan repayment contract. A clinician may work full-time, defined as 40 hours per week, or part-time, defined as a minimum of 20 hours to a maximum of 39 hours per week at the approved practice site(s).
   Full-time practitioners must spend a minimum of 32 hours per week providing direct client care at the approved practice site(s) and a minimum of 50% of that time (16 hours) must be spent providing SUD treatment. The remaining eight hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s).
   Part-time practitioners must spend a minimum of 16 hours per week providing direct client care at the approved practice site(s)and a minimum of 50% of that time (eight hours) must be spent providing SUD treatment. The remaining four hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s).

3. **Are practice sites required to meet specific criteria?**
   Yes. The Substance Use Disorder Professional Loan Repayment Program requires practice sites to accept Medicaid/ Medicare and to serve all clients regardless of inability to pay. The exception to this requirement is free clinics. Other requirements may apply, depending on the program.

   An ***Employer Agreement*** , completed by an official of the employer, must beincluded with the application. This form ***cannot*** be completed/signed by the applicant unless it is a solo private practice.

   Practice sites must assure that those selected for loan repayment work the appropriate number of hours and adhere to program requirements. In addition, practice sites must agree to complete semi-annual Patient Activity Reports (PAR) providing data on clients and client visits by payer source – see Glossary of Terms.

4. **What are the benefits of the loan repayment programs?**
   Loan repayment programs enable a health professional to work in an underserved community while receiving assistance with health professional education/training debt. Selected full-time applicants ***may**** receive up to $25,000 per year for a two-year contract. Part-time participants may receive up to half of the full-time amount. Payments are tax-exempt.
   *If an applicant's outstanding balance for ***qualifying*** educational loan debt is **less** than the maximum award amount, the SUDLRP will pay the remaining ***qualifying*** educational loan balance.

5. **How long is the loan repayment commitment?**
   The commitment for the Ohio SUDLRP program is two years.

6. **What happens if I receive loan repayment but then change my mind or relocate before the contract ends?**
   Failure to complete a service obligation results in a significant penalty the practitioner must repay to the State of Ohio. Depending upon the funding source used to pay a contract, the penalty may be a) three times the amount the department agreed to repay, or b) a sum equal to the amount paid to or on behalf of the practitioner, plus $7,500 for each month of service remaining in the contract term and interest at the prevailing rate. ***The practitioner will be responsible to pay whichever amount is greater.*** Any amount that ODH is entitled to recover shall be paid within one year from the date that ODH determines that the practitioner has breached the contract.
   The department may temporarily suspend a participant's contract in the event that personal or medical circumstances prohibit the individual from serving for a temporary situation. For example, maternity leave or other medical situations may be unavoidable and/or unforeseen and may require the department to suspend a practitioner's contract and later extend the contract term. On rare occasions, when practice sites have closed or practitioners have been terminated from their position, the department will work with the practitioner to find an eligible practice site in order to complete the service obligation. Practitioners may not initiate transfers to other practice sites without the expressed approval of ODH. Doing so may result in a determination by the department that the practitioner has failed to complete his/her service obligation and will be held responsible for a penalty repayment for default.

7. **How are loan payments made?**
   Payments are made directly to the loan repayment participants. Participants submit an *Invoice for Payment* document to ODH to generate payments. Within 45 days after receiving the payment, loan repayment participants must complete and submit to ODH the *Payment Verification* form, along with required loan balance statements. This confirms that the payments received from ODH were applied toward the outstanding qualifying loans.

8. **Are there other obligations by the practitioner or the site?**
   Yes. Semi-annual Patient Activity Reports (PAR), providing the number of clients and client visits by payer type (e.g., private insurance, Medicaid, sliding fee scale discount, self-pay full fee, etc.) are required. Numbers are reported for both the practice site and for the practitioner. Changes to approved practice site(s) or the addition of practice sites must receive prior approval from ODH. Both the practitioner and practice site must contact ODH immediately to discuss any desired changes in practice sites.

9. **What is contained in the loan repayment contract offered to those selected to receive an award?**
   Loan repayment contracts are based on standard language used by ODH, but also contain provisions specific to the Ohio SUDLRP. Contracts outline the obligations of the practitioner receiving a loan repayment award and the obligations of ODH. Included among those obligations are the practice site name and address, minimum hours per week, program definitions, reporting requirements, contract start and end dates, amount of loan repayment, practitioner accountability and certifications, contract default provisions, and contract termination and/or waiver of obligations.

10. Is an applicant who currently receives loan repayment from the National Health Service Corps (NHSC) or other loan repayment programs (LRPs) eligible to apply for the state loan repayment program?

Applicants may apply for the Ohio SUDLRP program while under contract with the NHSC or other LRPs, but the obligation must be **completed** prior to receiving a loan repayment contract with the state.

11. What is the National Student Loan Data System?

The National Student Loan Data System (NSLDS) can be accessed at: https://nslds.ed.gov/nslds/nslds_SA/.

The NSLDS is the U.S. Department of Education's central database for student aid. To retrieve your loan information, follow the steps below:

a. Log into the NSLDS site (create Free Application for Student Aid ID, if needed).
b. Print Loan Summary page.
c. Click on the loan number of each loan and print the loan details specific to that loan.
d. Include the information for all ***qualifying*** loans with your Loan Repayment Application.

Contact Information:

Nick Tremitiedi
Behavioral Health Workforce Program Coordinator
Ohio Department of Health
Primary Care Office
246 North High Street, 5th floor Columbus, OH 43215
Email: nicholas.tremitiedi@odh.ohio.gov
Phone: (614) 644-8049

GLOSSARY OF TERMS

Qualifying Loan Debt:

- ***Qualifying loan debt*** is any outstanding educational loan(s) that resulted in the eligible discipline the applicant is using to apply for the SUDLRP. (Most undergraduate debt is ineligible for LRP, as is any current degree program that has not been completed.)
- If an applicant's outstanding balance of ***qualifying*** educational loan debt is ***less*** than the maximum award amount, the SUDLRP will pay the remaining ***qualifying*** educational loan debt balance.

Sliding Fee Scale/Financial Assistance Documents:

(must be in place a minimum of six months prior to applying for SUDLRP)

- *Policy & Procedure:* needs to explain how your agency assesses and assists those clients/patients that are indigent/underinsured or otherwise unable to pay for services.
- *Sliding Fee/Subsidy Scale*: must be based on the current family poverty guidelines (FPG).
- *Client/Patient Application*: submit a copy of what is given to the client to complete.

Patient Activity Report (PAR):

- One-page document that is completed by the practitioner twice a year that captures the previous six-month client payer source data for both the practice site and the individual practitioner's clients/patients (Jan. 1 to June 30 and July 1 to Dec. 31).
- This is a fillable/PDF form that requires the number of unduplicated clients/patients seen/treated in each of the following payer sources Medicaid, Medicare, Sliding Fee Scale, Full Fee self-pay, No Charge or No Payment by client/patient, Private Insurance, or Other.

Tax-Exempt:

- A practitioner who receives an award for the SUDLRP ***does not*** include this LRP award as income, based on the federal act titled "The Patient Protection and Affordable Care Act." https://www.govinfo.gov/content/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf

Health Professional Shortage Areas (HPSAs):

- Health professional shortage areas (HPSAs) can be geographical areas, populations, or facilities. These areas have a shortage of primary, dental, or mental health care providers. In addition, all federally qualified health centers (FQHCs) and certain rural health clinics, state correctional institutions, free clinics, and state psychiatric hospitals are designated as facility HPSAs for mental health. For more information on HPSAs, visit https://data.hrsa.gov/tools/shortage-area/hpsa-find.

Department of Health

OHIO HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM
APPLICATION FORM

Date Application Received by ODH: _____

I. Applicant Information

Name
Last | First | MI | Maiden

Home Phone

Home Address

Cell Phone

City | State | ZIP+4

Email

Home County | Place of Birth

Date of Birth

Race *(select all that apply)*
- American Indian/Alaskan Native
- Asian
- Black or African American
- Native Hawaiian/Other Pacific Islander
- White
- Other

Ethnicity *(select only one)*
- Hispanic, Latino, or Spanish Origin
- Non-Hispanic, Latino, or Spanish Origin

Languages Spoken *(other than English)*

Physicians:
Do you have a DATA 2000 Waiver? Yes No

Do you provide Medication-Assisted Treatment? Yes No

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

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

Ohio License Number

Ohio Medicaid Number *(if applicable)*

Discipline

(enter other discipline here)

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 still completing 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)*

- ☐ Enrolled in final year of training program or residency
- ☐ Practicing in Ohio
- ☐ Practicing outside of Ohio
- ☐ Not currently in practice

Credentials *(required before beginning the program)*

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. Have you participated in any Ohio Loan Repayment Programs before? ☐ Yes ☐ No

B. Do you receive any type of educational loan repayment/assistance through your employer? ☐ Yes ☐ No

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

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

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

F. 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 (m/d/yyyy)

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 (m/d/yyyy)

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. For additional space for Section B., please attached a separate page with the corresponding lender information.

A. Applicant Information

Name (Last, First, MI) _____ Email Address _____

Home Address _____

City _____ State _____ ZIP _____ Telephone Number _____

Have you ever defaulted on any of your student loan obligations? ☐ Yes ☐ No

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.

_____ _____

Applicant's signature Date (m/d/yyyy)

Department of Health

OHIO HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM
EMPLOYER AGREEMENT

On behalf of (Employer Name) I certify that if (Applicant's Name) is awarded a loan repayment contract with the state of Ohio, the above-named agency will do the following:

1. Employ (Applicant's Name) (herein referred to as the Applicant) for the duration of the loan repayment contract at the practice site(s) (herein referred to as the Site) listed below:

   a) Practice Site #1 Name

      Address City ZIP+4

   b) Practice Site #2 Name

      Address City, ZIP+4

   c) Practice Site #3 Name

      Address City, ZIP+4

2. Ensure the Applicant works at least 45 weeks each service year, at the above-named practice site(s), for the appropriate number of hours per week, defined as:
   a) *Full-time practice* – means working a minimum of 40 hours per week. Applicant must spend a minimum of 32 hours providing direct patient care at the approved practice site(s). The remaining eight hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s)
   or
   b) *Part-time practice* – means working a minimum of 20 hours and a maximum of 39 hours per week. Applicant must spend a minimum of 16 hours providing direct patient care at the approved practice site(s). The remaining four hours may be spent teaching and/or performing practice-related administrative activities at the approved practice site(s).

3. Provide a competitive salary to the Applicant, without using the loan repayment benefit to offset the Applicant's salary.

4. Immediately notify the Loan Repayment Program Coordinator at the Ohio Department of Health if:
   a) the Site terminates the Applicant;
   b) the Applicant resigns from the Site;
   c) the Applicant goes on extended leave lasting longer than three weeks; or
   d) the Applicant is out of the office for 35 days or more during the service year.

5. Agree not to change the **Applicant**'s practice site without prior, written approval from the Ohio Department of Health.

6. Make health services available to individuals without regard to inability to pay for health services or payment for health services under the Medicare Insurance Plan, Ohio's Title XIX Medicaid Insurance Plan, or Ohio's Title XXI Children's Health Insurance Plan.

7. Use a scale based on 200% of the current federal poverty guidelines *if utilizing a Sliding Fee Scale (SFS) for patient discounts*.

   Check here if no SFS is used

8. Post or prominently display a statement expressing that no one will be denied access to services due to an inability to pay. (Attach a copy of the posted notification with application.)

9. Provide culturally appropriate primary care, dental, and/or mental health care services.

10. Assure data collection as necessary to complete semi-annual Patient Activity Reports, due January 15 and July 15 for the preceding six-month period. The reports include both the Site's and the Applicant's patients and patient visits by payer type.

The signature of the Site Official below confirms that the above-named site agrees to comply with the requirements set forth in this Agreement if a loan repayment contract is awarded to the Applicant named in this Agreement:

Printed Name of Site Official Title

Email Address Phone

Signature _____ Date

Department of Health

OHIO PRACTICE SITE SUMMARY
Ohio Dental Hygienist Loan Repayment Program Ohio Dentist Loan Repayment Program
Ohio Physician Loan Repayment Program
Ohio SUD Professional Loan Repayment Program
State Loan Repayment Program

Directions: Complete one Practice Site Summary form for each site where the applicant practices or will practice. This page *cannot* be completed by the applicant unless he or she is the owner of the practice.

I. Employer and Practice Site Information

Employer Name

Employer Address City, Zip+4

Practice Site Name

Practice Site Address City, Zip+4

II. Type of Practice Site

- ☐ Federally Qualified Health Center
- ☐ Certified Rural Health Clinic
- ☐ Free Clinic
- ☐ Office Based Opioid Treatment (OBOT)
- ☐ Opioid Treatment Program (OTP)
- ☐ Rural Communties Opioid Response Program (RCORP)
- ☐ Federally Qualified Health Center Look-Alike
- ☐ Critical Access Hospital
- ☐ Community Behavioral Health Agency
- ☐ State Correctional Facility
- ☐ Local Health Department
- ☐ Other (specify)_____

III. Applicant (Clinician) Information

Number of hours per week clinician practices or will practice at this practice site location? Hours per Week

Applicant Name

Current Employment Contract (Start Date) to (End Date)

Number of hours per week clinician spends on each of the following job duties at this practice site per week:	Client/Patient	Teaching	Administration	Other

Percentage of client/patient hours per week spent providing SUD treatment: %

IV. Practice Site Profile

A. Does this practice participate in the Ohio Medicaid program? ☐ Yes ☐ No Medicaid #

B. Does this practice accept new Medicaid-eligible clients/patients? ☐ Yes ☐ No

C. Does this practice accept assignment for Medicare? ☐ Yes ☐ No Medicare ID#

D. Does this practice see all patients regardless of their ability to pay? ☐ Yes ☐ No

E. Does this practice utilize a sliding fee scale (SFS), or provide other financial assistance for uninsured patients. ☐ Yes* ☐ No *If yes, include a copy of SFS or financial assistance policy/procedures with the application

F. Is this practice not-for-profit? ☐ Yes ☐ No

G. What percentage of patients served by the practice are of racial and ethnic minorities? %

H. Provide the practice site's payer mix data for the most recent 12-month period. Provide actual number for unduplicated clients/patients. Reporting Period: to

Payer	Number of Unduplicated Patients	Percentage of Total Patients
Medicaid		0.00%
Medicare		0.00%
Sliding Fee Scale		0.00%
Full Fee Self-pay		0.00%
No Charge/No Payment by Client		0.00%
Private Insurance		0.00%
Other (explain)		0.00%
TOTALS	0	0.00%

I. Does this practice provide integrated primary care and behavioral health care? ☐ Yes ☐ No

J. Does this practice utilize telehealth services? ☐ Yes* ☐ No

*** If yes, through which of the following?** ☐ Originating Site ☐ Distant Site

V. Practice Site Contact Person and Certification

Site contact person if applicant is awarded loan repayment:

Contact Person's Name | Contact Person's Position

Contact Person's E-Mail Address | Contact Person's Phone

☐ I certify that the information provided above is correct and can be verified with billing records.

Printed Name of Person Completing Survey | Title | Date

_____ | E-Mail Address | Phone

Signature of Person Completing Survey