



**Ohio Dentist and Dental Hygienist  
Loan Repayment Programs**

**Ohio Application Guidance and Instructions**

**Ohio Department of Health  
Primary Care Office  
246 North High Street  
Columbus, Ohio 43215**

## **Background**

The Ohio Dentist Loan Repayment Program (ODLRP) and the Ohio Dental Hygienist Loan Repayment Program (ODHLRP) are administered by the Primary Care Office within the Ohio Department of Health (ODH). The ODLRP and the ODHLRP seek general and pediatric dentists and dental hygienists to provide culturally competent dental services to underserved populations located in selected dental Health Professional Shortage Areas (HPSAs) and Dental Health Resource Shortage Areas. Shortage areas can be found in rural and urban communities across Ohio. In return, the ODLRP and the ODHLRP assist dentists and dental hygienists in their repayment of outstanding qualifying educational loans.

The ODLRP and the ODHLRP seek general and pediatric dentists and dental hygienists who demonstrate the characteristics for and an interest in serving the state's underserved populations and remaining in HPSAs or other underserved areas beyond their service commitment. It is important to remember that service to underserved and vulnerable populations, not the repayment of educational loans, is the primary purpose of the ODLRP and the ODHLRP.

## **Eligibility**

Currently practicing general and pediatric dentists and dental hygienists working in underserved areas of Ohio are eligible to apply. In addition, dental and dental hygiene students in their final year of training, and dental residents in their last year of general or pediatric residency training are also eligible to apply for the programs.

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 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). Part-time practitioners must spend a minimum of 16 hours per week providing direct patient care at the approved practice sites(s). 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 patient care hours under certain circumstances. To qualify as clinical practice, teaching must occur at the approved practice site.

All practice sites must be located in either a federally-designated dental Health Professional Shortage Area (HPSA) or in a state-defined Dental Health Resource Shortage Area as defined in Ohio Administrative Code Section [3701-56-04](#). To search for HPSAs, visit <http://hpsafind.hrsa.gov/>. The Ohio Department of Health can provide assistance in determining if a dental practice site is located in an area that will qualify as a Dental Health Resource Shortage Area. See Contact section (page 9) of these instructions for contact 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 on page three. Applications and supporting documents must be postmarked on or before Saturday, February 15, 2020.

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

## Required Documents

The applicant must submit the following documents:

1. Ohio Loan Repayment Program Application\*
2. 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 (page 8).
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 dental services, completed by applicant's employer)
5. Sliding Fee Scale (SFS) used at the practice site and, if applicable SFS policy (see Practice Site Summary)
6. Photo of site's lobby/registration area sign stating no person will be denied care based upon an inability to pay for the services
7. Current résumé or curriculum vitae
8. Current Ohio Dental or Dental Hygiene License<sup>^</sup>(copy)
9. Background and Biographical Statement narrative (refer to Section IV of the application)
10. Position 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.

\*Form is available on the [Ohio Department of Health website](#).

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

# APPLICATION INSTRUCTIONS

## 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 “Race”; choose only one option for “Ethnicity.” 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. “Other” includes suburban, adequately served areas in the city, etc.

### **II. Education and Credentials**

Respond to all components, including dates of attendance and graduation or anticipated graduation date. If you attended more than one dental or dental hygiene school, list only the one from which you graduated.

### **III. Obligations**

Individuals with an existing obligation to a state or federal government are not eligible for the loan repayment programs *unless* the obligation will be fulfilled prior to beginning an Ohio loan repayment contract. This includes loan repayment programs in other states; National Health Service Corps Loan Repayment, Scholarship, or Students to Service Programs; Ohio’s MEDTAPP program; the Ohio FQHC Dental Residents to Service Loan Repayment Program; the Ohio Dentist Free Clinic Loan Repayment Program; active military obligations; or employment contracts that provide loan repayment or impose a service obligation. Those who have participated in the Ohio Dentist or Dental Hygienist Loan Repayment Program for the maximum allowable number of years are not eligible.

### **IV. Background and Biographical Statements**

In narrative form, please respond to all seven items listed in Section IV of the application in the order that they appear. Type 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 school loans with other non-health professional training 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 which reflect the new consolidated loan.

#### **SECTION B: Lender Information**

In the table provided, enter each loan for which the applicant is 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 Frequently Asked Questions, page 8). **Please note that if you have defaulted on any student loan obligation, you may not be eligible for the Ohio Dentist or Dental Hygienist 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**

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 for information about the additional Employer(s). Complete the agreement electronically, then print and sign. Signed agreement must be included with the Loan Repayment Application. **Please note:** If the practice site does not use a standard sliding fee scale for discounts to patients whose incomes are below 200% of poverty, the box in item #7 must be checked. If the practice site offers a sliding fee scale, it must be included with the application.

### **Practice Site Summary**

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. If the practice site offers a sliding fee scale (SFS), please include a copy of the SFS and corresponding SFS policy. A photo of the waiting room or lobby sign (see #8 of Employer Agreement) must also be included with the Practice Site Summary. 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 complete, the form must be printed and signed, then submitted with the applicant's Loan Application.

***The application and all required documents must be postmarked on or before Saturday, February 15, 2020.*** Mail completed applications to:

Ohio Dentist and Dental Hygienist Loan Repayment Programs  
Ohio Department of Health  
Primary Care Office  
246 North High Street, 6<sup>th</sup> Floor  
Columbus, OH 43215

**Mailing Checklist:**

- ☐ Application
- ☐ Employer Agreement (one per employer)
- ☐ Practice Site Summary (complete one per practice site)
- ☐ Background and Biographical Statements narrative
- ☐ Loan balance statements (one per loan requested for repayment)
- ☐ Original loan documents if health professional training loans were consolidated with non-health professional training loans, or if consolidated with another person's loans
- ☐ Résumé or curriculum vitae
- ☐ Ohio dental or dental hygiene license (copy)
- ☐ Practice site's Sliding Fee Scale and policy, if applicable\*
- ☐ 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
- ☐ Position description
- ☐ Employment Contract (copy)

\* SFS and accompanying policy are required if site uses a sliding fee scale and the box in item 7 of the Employer Agreement is unchecked

## FREQUENTLY ASKED QUESTIONS

### **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 mental health professionals to provide services to the residents of the area. In addition, the programs assist primary care physicians, mental health providers and dental professionals who are dedicated to working with the underserved in Ohio to repay health professional training loans. Retention of providers in the underserved community is the primary goal of the programs.

### **Who is eligible to apply for loan repayment?**

Specific to the Ohio Dentist Loan Repayment Program (ODLRP) and Ohio Dental Hygienist Loan Repayment Program (ODHLRP), applicants must be currently practicing dentists or dental hygienists, in the final year of dental or dental hygiene school, or in the final year of a general or pediatric dental residency training program at the time of application. If an applicant has an existing obligation to a government or other entity, the obligation must be met prior to beginning a loan repayment contract. The applicant's practice site must be located in a HPSA or Dental Health Resource Shortage Area. 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 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). Part-time practitioners must spend a minimum of 16 hours per week 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).

### **Are practice sites required to meet specific criteria?**

Yes. All loan repayment programs require practice sites to accept Medicaid and to serve all patients regardless of inability to pay. The exception to this requirement is free clinics. Other requirements may apply, depending on the program. As part of the loan repayment application, an Employer Agreement, completed by an official of the employer, must be included.

For purposes of Ohio's loan repayment programs, free clinics are considered to be Dental Health Resource Shortage Areas regardless of whether the clinic is located in a geographic area that is designated as a Dental Health Resource Shortage Area. Practitioners serving in free clinics are eligible to participate in Ohio's loan repayment programs.

A free clinic is defined as, "A nonprofit organization exempt from federal income taxation under section 501(c)(3) of the Internal Revenue Code, or a program component of a nonprofit organization, to which both of the following apply:

- (a) Its primary mission is to provide health care services for free or for a minimal administrative fee to individuals with limited resources; and
- (b) It facilitates the delivery of health care services through the use of volunteer health care professionals and voluntary care networks (in addition to any paid staff)."

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 reports providing data on patients and patient visits by payer source.

### **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 training debt. Selected full-time applicants may receive up to \$25,000 per year for an initial two-year contract. Participants who retain eligibility and wish to continue with the program may receive up to \$35,000 for years three and four. Part-time participants may receive up to half of the full-time amounts. Payments are tax-exempt.

### **How long is the loan repayment commitment?**

An initial contract is two years. Practitioners who wish to continue in the program after meeting all contractual obligations of the initial contract may renew the contract for up to two additional one-year terms. The minimum commitment for the program is two years and the maximum length of time a practitioner can participate is four years.

**What happens if I receive loan repayment but then change my mind or relocate before the contract ends?**

Failure to complete the service obligation results in a significant penalty the provider 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, plus 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, practice sites have closed or practitioners have been terminated from their positions. In these situations, 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 the Ohio Department of Health (ODH). Doing so may result in a determination by the department that the practitioner has failed to complete his or her service obligation and repayment of the penalty for default.

**How are loan payments made?**

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

**Are there other obligations by the practitioner or the site?**

*Semi-Annual Patient Activity Reports*, providing the number of patients and patient visits by payer type (e.g. private insurance, Medicaid, sliding fee scale discount, self-pay full fee, no payment, and other payment types) are required. Numbers are reported for both the practice site and for the participating 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.

**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 individual loan repayment program (e.g. ODHLRP, ODLRP, OPLRP). Contracts outline the obligations of the practitioner receiving a loan repayment award and the obligations of the 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.

**Is an applicant who currently receives loan repayment from the National Health Service Corps (NHSC) eligible to apply for the state loan repayment program?**

Applicants may apply for Ohio loan repayment programs while under contract with the NHSC, but the obligation must be complete prior to receiving a loan repayment contract with the state.

**What is the National Student Loan Data System?**

National Student Loan Data System (NSLDS) can be accessed at [https://nslds.ed.gov/nslds/nslds\\_SA/](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:

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



## **Contact**

Ohio Dentist and Dental Hygienist Loan Repayment Programs contact information:

### **Oral Health Workforce Coordinator**

Ohio Department of Health  
Primary Care Office  
246 North High Street, 6<sup>th</sup> Floor  
Columbus, OH 43215

Email: [PCRH@odh.ohio.gov](mailto:PCRH@odh.ohio.gov)

Phone: (614) 644-8496



**OHIO EMPLOYER AGREEMENT**  
Ohio Dental Hygienist Loan Repayment Program  
Ohio Dentist Loan Repayment Program  
Ohio Physician Loan Repayment Program  
State Loan Repayment Program

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

1. Employ \_\_\_\_\_ (herein referred to as the Practitioner) for the duration of the loan repayment contract at the  
(Applicant's Name)  
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 Practitioner 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. Practitioner 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. Practitioner 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 Practitioner, without using the loan repayment benefit to offset the Practitioner's salary.
4. **Immediately notify** the Loan Repayment Program Coordinator at the Ohio Department of Health if:
  - a) the Site terminates the Practitioner;
  - b) the Practitioner resigns from the Site;
  - c) the Practitioner goes on extended leave lasting longer than three weeks; or,
  - d) the Practitioner is out of the office for 35 days or more during the service year.
5. **Agree not to change the Practitioner'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 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.
9. Provide culturally appropriate primary care, dental and/or mental health care services.
10. Assure data collection as necessary to complete the semi-annual Patient Activity Reports, due January 15 and July 15 for the preceding six-month periods. The reports include both the Site's and the Practitioner'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 Practitioner named in this Agreement:

Name (printed) of Site Official _____	Title _____
E-mail Address _____	Phone _____
Signature _____	Date _____



# 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 Address		Home Phone
City		Cell Phone
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) Physicians: Do you have a DATA 2000 Waiver? Yes No
Geographic Background City State Rural Inner City Appalachian Other Ages _____ to _____ _____ to _____ _____ to _____		Do you provide Medication-Assisted Treatment? Yes No 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 Physician Dentist Registered Dental Hygienist Other		National Provider Identifier (NPI) (if applicable)
Specialty (select all that apply) Adolescent Medicine General IM IM/PEDS Child/Adolescent Psych Geriatric Psych OB/GYN Family Practice Geriatrics Pediatrics General Psych GPR/AEGD 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: Dates of Attendance:                      through  Residency Program:  Dates of Attendance:                      through  Any additional training programs:  Dates of Attendance:                      through				City/State: Date of graduation  City/State: Date of graduation:  City/State: Date of completion:	
<b>Current Status</b> <i>(select one)</i> <input type="checkbox"/> Enrolled in final year of training program or residency <input type="checkbox"/> Practicing in Ohio <input type="checkbox"/> Practicing outside of Ohio <input type="checkbox"/> Not currently in practice				<b>Credentials</b> <i>(required before beginning the program)</i> List State(s) where you currently hold a license or certification:	
<b>Are you Board certified or eligible?</b>  <div> <input type="checkbox"/> Yes           <input type="checkbox"/> No           <input type="checkbox"/> Pending           <input type="checkbox"/> N/A         </div>				<b>Note any licensure restrictions</b> <i>(if applicable)</i>	

### 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

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

### A. Applicant Information

Name (Last, First, MI)

E-Mail 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			

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



**OHIO PRACTICE SITE SUMMARY**  
 Ohio Dental Hygienist Loan Repayment Program  
 Ohio Dentist Loan Repayment Program  
 Ohio Physician 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. Applicant (Clinician) Information**

Applicant's Name

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

Current Employment Contract (Start Date)

to

(End Date)

Hours per Week

Number of hours per week clinician spends on each of the following job duties at this practice site per week:

Patient Care

Teaching

Administration

Other

**III. Practice Site Profile**

A. Does this practice participate in the Ohio Medicaid program?

Yes

No

Medicaid #

B. Does this practice accept new Medicaid-eligible 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) for uninsured patients whose incomes are at or below 200% of the Federal Poverty Guidelines?

Yes\*

No

\*If yes, include a copy of SFS 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 numbers for unduplicated patients.  
Reporting Period: \_\_\_\_\_ to \_\_\_\_\_

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

I. Is this practice a Patient-Centered Medical Home? Yes\* No  
*\*If yes, through which of the following?* AACHC JC PCMH NCQA URAC

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

K. Does this practice utilize telehealth services? Yes\* No  
*\*If yes, through which of the following?* Originating Site Distant Site

#### IV. 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

Signature of Person Completing Survey

E-Mail Address

Phone