Student Loan Repayment Program (SLRP)
Application Instructions

Missouri Department of Health and Senior Services
Office of Rural Health and Primary Care

Contact Information for the SLRP Program
Phone #: 1-800-891-7415 or 573-751-6441
Fax #: 573-522-8146
Email: DHSS.LoanRepayment@health.mo.gov
Website: https://health.mo.gov/living/families/primarycare/loanrepayment/slrp.php.

Note: You must complete the entire application to be considered for funding.

Applications are accepted January 1 – March 1 of each year.

Introduction

These applications instructions are for persons applying for a Health Professional Student Loan Repayment Program (SLRP) Award. These step-by-step instructions assist in completing the application, including the methods which are available for submitting the completed application. Contact the SLRP program with any questions and assistance with completing the application and required documentation.

The SLRP is a competitive federal grant program that allocates funds to states to award funding for educational loan repayment to Missouri licensed practicing psychiatry, medical, and dental health professionals in exchange for services in Missouri areas with a shortage of mental health, medical, and dental professionals. Applicants must meet the qualifications associated with the program provisions and agree to work in a Missouri Health Professional Shortage Area (HPSA).

Program Provisions are found in the SLRP Policies and Procedures and the SLRP Program Code of State Regulations (CSR) PDF Document *(19 CSR 10-3.030).*

Before You Apply:

- Carefully review all the program provisions found in 19 CSR 10-3.030 PDF Document.
- Make sure must understand all the program provisions, penalties, and how contract breaches occur.
    - There are *serious* penalties associated with breaching program contracts, which could result in paying back the entire loan amount awarded to you in addition to interest and other financial penalties.

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SECTION 1: APPLICANT'S PERSONAL INFORMATION

Fill this entire section out with requested demographic information.

1. Provide your full legal name: Last Name, First Name, and Middle Initial. Please do not include nicknames or abbreviated names.
2. Provide your full Social Security Number.
3. If applicable, provide your Maiden Name or Any Other Names Used.
4. Provide your full Date of Birth.
5. List an Email Address that you check regularly. The SLRP utilizes email as a source of communication.
6. Provide your Hone Phone Number; Cellular Phone Number; Work Phone Number. Provide all applicable telephone numbers.
7. Provide the Household Income from Most Recent Income Tax Return. This is the Adjusted Gross Income (AGI) as detailed on your most recent Federal Income Tax Return.
8. Provide the Number of Dependents in your household. This number should reflect the number of persons you are financially responsible for within the home and reflected on your most recent Federal Income Tax Return.
9. Current Address: Please provide the address where you permanently reside.
10. If applicable, identify any Languages Spoken Fluently Other Than English. If you do not speak any other languages, leave this field blank.
11. Select Yes or No regarding if you are a U.S. Citizen.

DEMOGRAPHIC INFORMATION CHECK ALL THAT APPLY

Award selections will not be determined by this section.

12. This information is used for reporting purposes and does not affect the determination of awards. Please select the following:
    - Gender: Select Male or Female.
    - Ethnicity: Select Hispanic or Latino or Not Hispanic or Latino.
    - Race: Select all that apply.

SECTION 2: APPLICANT'S EMPLOYMENT INFORMATION

10. Provide the Full Name of your Employer.
11. Provide the Street Address of your employer. Include the City, State, Zip Code, and County.

12. Provide the Work Telephone Number & Extension.
13. Provide a Work Email Address.
14. Provide your Supervisor's Name.
15. Provide your Supervisor's Work Telephone Number & Extension.
16. Provide your Supervisor's Work Email Address.
17. Provide the Facility Site Address.
    - ✓ If different from the answer to number 11.
18. Under Applicant's Title, provide your employment title.
19. Under Date Employed, provide the date on which you were first employed.
20. Under This Facility Is, select all that apply:
    - ✓ Public
    - ✓ Private
    - ✓ Non-Profit
    - ✓ For-Profit
21. Provide your Total Hours Worked Per Week.
22. Provide your Direct Patient Care Hours Per Week.
    - ✓ The number of direct patient care hours out of the total number hours worked during a typical workweek should be reported in this field.
    - ✓ Direct Patient Care hours include hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring.
    - ✓ For the purpose of counting direct patient care hours, it is acceptable to include charting, notifying patients of test results, and telehealth clinical care.
        - ✓ The provider shall follow the statutes applicable to providing direct patient care via telehealth.
    - ✓ Do not include non-direct patient care, when calculating the direct patient care hours.
        - ✓ Do not include non-clinical work that does not provide direct diagnosis, treatment, or care of the patient.
    - ✓ Contact the program for any questions.
23. Select Yes or No regarding if you See Patients Regardless of Ability to Pay.

- ✓ You are attesting that you will provide services to the underserved populations, including those who are uninsured or underinsured, Medicaid and Medicare beneficiaries, and those with high deductibles.

SECTION 3: APPLICANT'S SCHOOL/RESIDENCY PROGRAM INFORMATION

24. Provide the name of your Last School Attended.

25. Provide the name of your Residency Program, if applicable.

26. Indicate the Date of Completion of your education.

- ✓ Must be entered as MM/DD/YYYY.

27. Select the Degree Earned. You must select one of the following:

- ✓ Allopathic Medicine (MD) – OB/GYN
- ✓ Allopathic Medicine (MD) – Internal Medicine
- ✓ Allopathic Medicine (MD) – Family Medicine
- ✓ Allopathic Medicine (MD) – General Practice
- ✓ Allopathic Medicine (MD) – Pediatrics
- ✓ Allopathic Medicine (MD) – Psychiatry
- ✓ Osteopathic Medicine (DO) – OB/GYN
- ✓ Osteopathic Medicine (DO) – Internal Medicine
- ✓ Osteopathic Medicine (DO) – Family Medicine
- ✓ Osteopathic Medicine (DO) – General Practice
- ✓ Osteopathic Medicine (DO) – Pediatrics
- ✓ Osteopathic Medicine (DO) – Psychiatry
- ✓ Doctor of Dental Surgery (DDS)
- ✓ Doctor of Medicine in Dentistry (DMD)

SECTION 4: ADDITIONAL INFORMATION

Information collected in this section is required for reporting purposes. Information in this section is not used for award selection.

SUBSTANCE USE DISORDER (SUD) AND TELEHEALTH QUESTIONS

28. Do You Provide SUD Services?

- ✓ Select Yes or No regarding if you provide SUD (Substance Use Disorder) services.

29. Do You Have a SUD License or Certification Issued by the State or National Crediting Agency?
    - ✓ Select Yes or No documenting if you have a SUD License or Certificate.
30. Do You Have Specific Training and Credentials to Provide Evidence-Based SUD Treatment?
    - ✓ Select Yes or No regarding if you have Specific Training and Credentials to Provide Evidence-Based SUD Treatment
31. Do You Provide any of the following services? Select all that apply:
    - ✓ Buprenorphine
    - ✓ Counseling
    - ✓ Both
    - ✓ Neither
32. Do You Possess a Data 2000 Waiver?
    - ✓ Select Yes or No regarding if you have Possess a Data 2000 Waiver.
33. If you answered Yes to Question 32, indicate the Panel Size which applies to your Data 2000 Waiver. Select one of the following Panel Sizes:
    - ✓ DW30
    - ✓ DW100
    - ✓ DW275
34. Are You a Telehealth Provider?
    - ✓ Select Yes or No regarding if you are a Telehealth Provider.
35. If you answered Yes to Question 34, indicate number of Approximate Hours Per Week Engaged in Telehealth.

APPLICANT'S EMPLOYMENT HISTORY IN UNDERSERVED AREAS

This information is collected for reporting purposes.

36. How Many Years You Have Provided Health Care Services in a HPSA/Rural Area?
    - ✓ Provide a numerical value. HPSA stands for Health Professional Shortage Area.
37. How Many Additional Years Do You Plan to Continue Working in a HPSA/Rural Area?
    - ✓ Provide a numerical value.
38. List All Employment Working in a Health Professional Shortage Area (HPSA/Rural Area). For each entry:
    - ✓ Indicate the County of the Employer.

- ✓ Indicate the No. of Years Served.
- ✓ Provide the Employer Name and your Job Title while employed there.
- ✓ Select either Part-Time or Full-Time.

SECTION 5: PROVIDER BILLING VERIFICATION

Obtain assistance from your facility billing department in completing Section 5.

39. Provide your National Provider (NPI) Number.
40. Provide your Medicaid Billing NPI.
    - ✓ Providers who bill MO Health Net (MHD) or MHD Managed Care plans directly for Missouri Medicaid patients, shall report their NPI.
    - ✓ If the provider does not bill MHD directly, provide the facility's Medicaid Billing NPI they utilize to bill for Missouri Medicaid patients.
41. Do you Accept Medicaid Fee-for-Service (FFS)?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ This will most likely be the same billing NPI number you reported in number 40.
    - ✓ If No or N/A: Explain briefly.
42. Do you Accept Medicaid Home State Health / or Current Replacement Plan?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ If No or N/A, Explain briefly.
    - ✓ If applicable: Identify the Replacement Plan.
43. Do you Accept Medicaid Missouri Care / or Current Replacement Plan?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ If No or N/A: Explain briefly.
    - ✓ If applicable: Identify the Replacement Plan.
44. Do you Accept Medicaid United Health Care/ or Current Replacement Plan?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ If No or N/A: Explain briefly.
    - ✓ If applicable: Identify the Replacement Plan.
45. Provide your Medicare Provider Transactional Access Number (PTAN).
    - ✓ Providers who bill Medicare directly for Missouri Medicare patients shall report their NPI.

- ✓ If the provider does not bill Medicare directly, provide the facility's Medicare Billing NPI they utilize to bill for Missouri Medicare patients.

46. Do you Accept Medicare FFS?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ If No or N/A: Explain briefly.
47. Do you Accept Medicare Advantage/ Part C Plans?
    - ✓ If Yes: Provide the corresponding Billing NPI Number.
    - ✓ If No or N/A: Explain briefly.
48. Are you Currently Enrolled in any other Medicare Plans?
    - ✓ If Yes: Specify the Plan.
49. Provide your Professional License Number.
50. Are You a Board Certified Physician? Select Yes or No regarding if you are a Board Certified Physician.
51. Provide your Board Certification Number, if applicable.
52. List the Names of Any Other States in Which You are Licensed to Practice and include the associated License Number(s).

SECTION 6: EDUCATIONAL DEBT INFORMATION

53. Do you have an Existing Service Obligation, such as NHSC?
    - ✓ If Yes: Provide the Date to be Completed; and
    - ✓ Indicate whether you are in Default of the Obligation. These may include service obligations associated with:
        - National Health Service Corps (NHSC) Federal Scholarship or Loan Repayment Programs;
        - Primary Care Resource Initiative for Missouri (PRIMO) Program;
        - Employment Sign-on bonuses; and
        - Other Programs.
54. If applicable, provide the Name of Program, a Contact Name, and a Contact Phone Number.
55. Have you ever Defaulted on a State or Federal Loan?
    - ✓ If Yes: List the name of the loan, type of the loan, and reason for default.
56. Only include Qualifying Debts in the table. List the following for each loan you would like considered for repayment:

- ✓ Lending Institution Name;
- ✓ Full Account Number;
- ✓ Remaining Balance; and
- ✓ Phone Number.

➢ Examples of Qualifying Educational Debt :

- ✓ Outstanding government (federal, state, or local) student loans;
- ✓ Outstanding commercial student loans;
- ✓ Consolidated or refinanced loans, so long as they are from a government (federal, state, or local) or private student loan lender and include only the qualifying educational loans of the applicant; and
- ✓ Graduate Plus Loans.

➢ Examples of Non-Qualifying Educational Debt :

- ✓ Loans for which the associated documentation cannot identify that the loan was solely applicable to undergraduate or graduate education of the applicant;
- ✓ Most loans made by private foundations;
- ✓ Fully repaid loans;
- ✓ Primary Care Loans;
- ✓ Parent Plus Loans (Graduate Plus do qualify);
- ✓ Personal lines of credit;
- ✓ Loans subject to cancellation;
- ✓ Residency loans;
- ✓ Credit card debt; and
- ✓ Loans currently in default status.

SECTION 7: DOCUMENTATION REQUIREMENTS

You must include the following documentation with your application in order for your application to be complete:

57. A Copy of Your Employment Contract:

- ✓ Attach a copy of your Employment Contract for the proposed practice site for a period of no less than two years.

58. A Copy of Your Professional License**:**

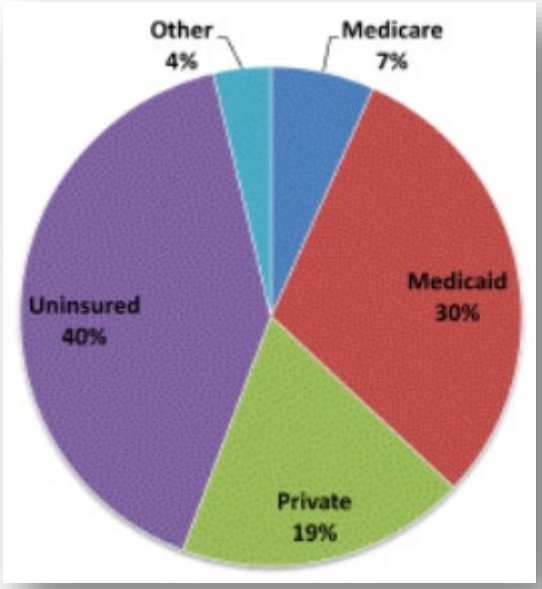
- ✓ Attach a copy of your Professional License.

58. Proof of Malpractice Insurance:

- ✓ Attach proof that you are insured. You may request a letter from your Malpractice Insurance carrier which states that you have coverage. You may also choose to submit a copy of your policy or certificate of liability insurance.

59. A Copy of the Payer Mix Report:

- ✓ Attach a copy of your facility's Payer Mix Report.
- ✓ The Payer Mix Report may be displayed by a pie chart, representing the charges billed to various types of insurance (e.g., Medicaid, Medicare, Private Insurance, Tricare, etc.). In place of a pie chart, you may submit a letter from your employer, on company letterhead, which lists these percentages.



60. A Copy of the Sliding Fee Scale:

- ✓ Attach a copy of your facility's Sliding Fee Scale or Sliding Fee Schedule.
- ✓ Sliding Fee Scales are variable prices for services based on the patient's ability to pay.
- ✓ Providers use this payment model to care for patients who cannot afford care, such as low-income and uninsured patients.
- ✓ You may also provide your facility's policies related to their Sliding Fee Scale or Sliding Fee Schedule.
- ✓ Sliding Fee Scale Example:

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Charge					
	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$12,490	$12,491-$15,613	$15,614-$18,735	$18,736-$21,858	$21,859-$24,980	$24,981+
2	0-$16,910	$16,911-$21,138	$21,139-$25,365	$25,366-$29,593	$29,594-$33,820	$33,821+
3	0-$21,330	$21,331-$26,663	$26,664-$31,995	$31,996-$37,328	$37,329-$42,660	$42,661+
4	0-$25,750	$25,751-$32,188	$32,189-$38,625	$38,626-$45,063	$45,064-$51,500	$51,501+
5	0-$30,170	$30,171-$37,713	$37,714-$45,255	$45,256-$52,798	$52,799-$60,340	$60,341+
6	0-$34,590	$34,591-$43,238	$43,239-$51,885	$51,886-$60,533	$60,534-$69,180	$69,181+
7	0-$39,010	$39,011-$48,763	$48,764-$58,515	$58,516-$68,268	$68,269-$78,020	$78,021+
8	0-$43,430	$43,431-$54,288	$54,289-$65,145	$65,146-$76,003	$76,004-$86,860	$86,861+
For each additional person, add	$4,420	$5,525	$6,630	$7,735	$8,840	$8,840

61. A Copy of Proof of Qualifying and Outstanding Educational Debt:

- ✓ Attach Proof of Qualifying and Outstanding Educational Debt.
  - ✓ View examples of Qualifying and Non-Qualifying Education Debt on Number 56.
- ✓ The most accurate way to submit proof of qualifying education debt is by submitting two reports per loan; an Account Statement and a Disbursement Report.
- ➢ The Account Statement includes:
  - ✓ Verification statement from the lender/holder; this could be evidenced by official letterhead;
  - ✓ The name of the borrower;
  - ✓ The account number;
  - ✓ The date of the statement;

- ✓ The current outstanding balance (principal and interest) or the current payoff balance; and
- ✓ Include the current interest rate.

➢ The Disbursement Report includes:

- ✓ Verification report from the lender/holder; this could be evidenced by official letterhead;
- ✓ The name of the borrower;
- ✓ The account number;
- ✓ The type of loan;
- ✓ The original loan date;
- ✓ The original loan amount; and
- ✓ The purpose of the loan.

➢ **Note**: For all federal loans, the National Student Loan Data System (NSLDS) may be used to verify the originating loan information.

- ✓ If you have multiple federal loans, you need only submit one (1) NSLDS report.
- ✓ The NSLDS report will contain the originating loan information for all of your federal loans.
- ✓ You must use your Federal Student Aid ID (FSAID) to log in.
- ✓ If necessary, you may create a FSAID.

➢ **Note**: In lieu of a disbursement report, the following may be submitted for review for non-federal loans; proof can be evidenced by official letterhead of the lender:

- ✓ A promissory note;
- ✓ A disclosure statement; or
- ✓ A letter directly from the lender containing the items outlined above, under "The Disbursement Report Includes".

59. A Copy of a Letter of Support or Recommendation from your Employer:

- ✓ Attach a Letter of Support or Recommendation from your Employer.
- ✓ In place of the Letter of Support or Recommendation, you may submit your Latest Performance Appraisal.
- ✓ The Letter of Support or Recommendation and/or your Latest Performance Appraisal.

60. A Copy of Your Official Job Description:

- ✓ Attach a copy of your Official Job Description.

- ✓ Your supervisor/director, or someone in the Human Resources Department may provide this to you.

61. List of Services Provided by your Employer:
    - ✓ Attach a List of Services Provided by your Employer.
    - ✓ This may be provided via a facility or employer pamphlet, given said pamphlet lists all general services provided (e.g., Family Medicine, Internal Medicine, Otolaryngology).
    - ✓ You may also print the list of services from your employer's website. Do **not** submit a charge master or fee schedule.
62. A Copy of Your Most Recent Credit Report:
    - ✓ Attach a copy of your Most Recent Credit Report.
    - ✓ You may obtain your credit report from the Federal Trade Commission's website: https://www.annualcreditreport.com/index.action.
    - ✓ You may be eligible for a free credit report.
    - ➢ The credit reports are used to verify:
        - ✓ Defaults on federal or non-federal payment obligations;
        - ✓ Uncollectable write-offs of federal or non-federal debts;
        - ✓ Active bankruptcies. A history of chapter 7 and/or chapter 13 bankruptcy does not disqualify you for a SLRP loan, provided the bankruptcy is listed as discharged;
        - ✓ Judgement liens from federal debt; and
        - ✓ Charge off accounts for federal debt (educational loans, FHS loans, etc.).

63. Print Your Full Name.
64. **SIGN AND DATE.**

SUBMISSION OF APPLICATION.

71. Once you have completed the application and attached the required documentation, you may submit your application. (*Submissions are accepted January 1 – March 1 of each year.*)

72. Submission Methods:

    a) **Electronic Submission:**

    Visit: https://health.mo.gov/living/families/primarycare/loanrepayment/slrp.php

    Select "SLRP Electronic Application Submission" at the top of the page.

Submit the completed application and required documentation.

b) **Scan and Email:** DHSS.LoanRepayment@health.mo.gov

c) **Fax:** (573) 522-8146

d) **Mail**:

Attn: SLRP Program
Missouri Department of Health and Senior Services
Office of Rural Health & Primary Care
PO Box 570
Jefferson City, MO 65102-0570