# SOUTH DAKOTA STATE LOAN REPAYMENT PROGRAM (SLRP) APPLICATION

Please type or print your responses.

1. Name (Last, First, Middle)

2. Permanent Adress (Street Address, City, State, Zip)

3. Home Phone (include area code)

4. Work Phone (include area code)

5. Birth Date

6. Place of Birth

7. Social Security Number

8. Are you a US Citizen?

9. Name of Professional Training Program

Dates Attended

Address (Street Address, City, State, Zip)

**Please provide verification of all loans. If loans have been consolidated, please provide verification of the source of the original loans.**

| | | | | |
|---|---|---|---|---|
| 10. Eligible Lender | Date Loan Originated | Outstanding Balance | Loan # | Lender Phone # |
| 11. Eligible Lender | Date Loan Originated | Outstanding Balance | Loan # | Lender Phone # |
| 12. Eligible Lender | Date Loan Originated | Outstanding Balance | Loan # | Lender Phone # |

13. Practice Specialty (if any)

14. Are you board certified?

Are you board eligible?

Date of Certification

Name of Board

15. License Information:

a. Type:

b. State:

c. Number:

d. Date Issued:

e. Expiration Date:

f. Restrictions:

16. Has your license ever been restricted or revoked?

17. Are any professional disciplinary actions pending? If yes, please attach an explanation.

18. Do you have an existing service obligation as a result of any educational loans?

If yes, please describe the obligation and when it will be completed. (Attach additional sheets, if necessary).

19. Are you in default or breach of contract for any student loans?

If yes, please explain. (Attach additional sheets, if necessary).

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20. References (List three individuals who will be in contact with you during the next three years.) Do not use temporary addresses.

(a) Name

Home Phone (area code)

Complete Permanent Address

(b) Name

Home Phone (area code)

Complete Permanent Address

(c) Name

Home Phone (area code)

Complete Permanent Address

21. When would you be available to begin practice under this program?

22. Please check the box that describes your stauts with regard to practice site selection:

- ☐ I do not have a specific Certified Eligible Entity in mind; please contact me to provide information.
- ☐ I am interested in practicing for one or more specific Certified Eligible Entities but have not signed an agreement.

  Name of Certified Eligible Entity (Entities):

- ☐ I have signed an agreement with Certified Eligible Entity to practice for two or mroe years.

  Name of Certified Eligible Entity:

  Address:

  Contact Name: Phone Number:

**Please print form at this time and complete the following information by hand. Once you have completed the form in its entirety, please fax or mail to location listed below.**

Print Form

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the South Dakota Department of Health to contact references and program directors listed in the application for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification, and providing willfully false information will result in disqualification from participation in this program.

SIGNATURE: _____DATE: _____
(Please sign your full name, in ink)

Please submit completed application to:

Nicole Beck
Health Professional Recruiter
South Dakota Department of Health
Office of Rural Health
600 East Capital Ave
Pierre, SD 57501
Phone: (605)773-2679
Fax: (605)773-5683

## Qualification Verification

**Each Clinician participating in the South Dakota State Loan Repayment Program must:**

1. Be a United States citizen.

2. Not have previously incurred an obligation for health professional service to the Federal, State or local government, or other entity unless the obligation is completely satisfied prior to the beginning of service under this program.

3. Not be in breach of a health professional service contract to the Federal Government, State or local government or other entity.

4. Not have a judgement lien against their property for a debt to the United States.

5. Provide full-time (defined by the practice site, but in no event less than 32 hours per week) clinical services for at least 45 weeks per year in a public or nonprofit entity private entity located and providing primary health care services in a current federally designated Health Professional Shortage Area (HPSA) appropriate for the discipline.

6. With the exception of obstetrician/gynecologists (OB/GYN) and certified nurse midwives, spend 80 percent of their full-time hourse providing clinical services in the ambulatory setting at the approved practice site, during normally scheduled office hours. For an OB/GYN practitioner (including certified nurse midwives), the majority of the full-time schedule (but not less than 21 hours per week) is expected to be providing ambulatory care services during normally scheduled office hours, with the remaining hours spent providing inpatient care to patients of the approved site, and/or in practice related administrative activities not to exceed 20 percent of their full-time tour. Time spent "on-call" does not count toward the 40-hour week.

7. Charge for their professional services at the usual and customary prevailing rates in the areas in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate (i.e. sliding fee scale) or not charged any fee.

8. In providing primary health services, will not, in the case of an individual seeking care, discriminate on the basis of the ability of the individual to pay for such care or on the basis that payment for such care will be madepursuant to Title XVIII or Title XIX of the Social Security Act (Medicare or Medicaid).

9. Accept assignment under Medicare (section 1842 (b) (3) (B) (ii) of the Social Security Act) for all services for which payment may be made under Part B of Medicare.

10. Enter into appropriate agreement with the South Dakota Department of Health that administers the State Plan for medical assistance under Medicaid to provide service to individuals entitled to medical assistance under the plan.

Having read the fore mentioned eligibility requirement, I do hereby affirm that I do qualify for participation in the South Dakota State Loan Repayment program.

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**Name** **Date**