SOUTH DAKOTA STATE LOAN REPAYMENT PROGRAM APPLICATION

SOUTH DAKOTA DEPARTMENT OF HEALTH

INSTRUCTIONS: Please email your completed application and required supporting documents to Amber.Hodgin@state.sd.us with a subject line of: State Loan Repayment Program. The required supporting documents include: (1) Verification of qualifying educational loans, (2) W-9 filled out with your personal information, (3) copies of your professional license, and (4) a copy of your practice site's sliding fee schedule.

Please fill out the application in its entirety. If the question does not apply to you, please put N/A. An unanswered question may lead to the dismissal of your application.

Please type or print your responses.

1. Name (Last, First, Middle)

2. Permanent Address

3. Home Phone (include area code)

Work Phone (include area code)

4. Email address

5. Birth date

6. Place of Birth (City, State)

7. Gender: Male ◯ Female ◯

8. Race: ◯ White ◯ Black or African American ◯ American Indian ◯ Alaskan Native ◯ Asian ◯ Native Hawaiian ◯ Pacific Islander ◯ Other

9. Social Security Number

10. Are you a U.S. Citizen? Yes ◯ No ◯

11. Name of College, University, or Technical School

Dates Attended

Address

For questions 12-14, if you need additional room, please fill out a separate sheet of paper with all your loan information.

12. Eligible Lender	Date Loan Originated	Outstanding Balance	Loan Number
13. Eligible Lender	Date Loan Originated	Outstanding Balance	Loan Number
14. Eligible Lender	Date Loan Originated	Outstanding Balance	Loan Number

Total Outstanding Balance _____

Updated: 9/27/2023

15. Are you Board Certified? Yes ◯ No ◯ Board Eligible Yes ◯ No ◯

Date of Certification ______ Name of Board ______

16. Licensee Information:

a. Discipline: ______

b. Specialty: ______

c. State: ______

d. Number: ______

e. Date Issued: ______

f. Expiration Date: ______

g. Restrictions: ______

17. Do you provide Substance Use Disorder services?
Yes ◯ No ◯

18. Do you have an Substance Use Disorder license or certification?
Yes ◯ No ◯

19. Are you a DATA 2000 Waiver Provider?
Yes ◯ No ◯

20. Are you a Telehealth Provider?
Yes ◯ No ◯

21. NPI Number: ______

To look up your NPI number, visit http://npinumberlookup.org/

22. Has your license ever been restricted or revoked? Yes ◯ No ◯

23. Are any professional disciplinary actions pending? Yes ◯ No ◯ If yes, please attach an explanation.

24. Do you have an existing service obligation as a result of any educational loans? Yes ◯ No ◯

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

25. Are you in default or breach of contract of any student loans? Yes ◯ No ◯

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

26. References (List three professional individuals who will be in contact with you during the next three years.)

(a) Name ______ Home Phone (include area code) ______

Complete Permanent Address ______

(b) Name ______ Home Phone (include area code) ______

Complete Permanent Address ______

(c) Name ______ Home Phone (include area code) ______

Complete Permanent Address ______

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

28. Will you practice half-time or full-time? _____

- "Full-time" service is defined in the NHSC statute as a minimum of 36 hours of direct patient care hours and 4 hours of administrative work per week for 40 hours per week, for a minimum of 45 weeks per year.
- "Half-time" service is defined in the NHSC statute as a minimum of 18 hours of direct patient care hours and 2 hours of administrative work per week for a minimum of 20 hours per week (not to exceed 39 hours per week) for a minimum of 45 weeks per year.

28. What will be your job title? _____

30. Please check the line that describes your status with regard to practice site selection:

_____ I do not have a specific practice site in mind; please contact me to provide information.

_____ I am interested in practicing for one or more specific practice site(s) but have not signed an agreement.

Name of practice site(s):

_____ I have signed an agreement with a practice site to practice for two or more years.

Name of practice site: _____

Address _____

Contact name _____ Phone number _____

Email _____

31. What is the type of setting for your practice site?

◯ Hospital ◯ Clinic ◯ Both

If both, please write hours worked at each location _____

Verification of Eligibility

Clinicians participating in the South Dakota State Loan Repayment Program (SLRP) must meet the following requirements. Please answer yes or no.

1. Do you have an outstanding contractual obligation for health care professional service to the Federal Government (e.g., a National Health Service Corps (NHSC) Scholarship or Loan Repayment Program obligation, or a NURSE Corps Loan Repayment Program obligation), a state loan repayment program (other than the one receiving Health Resources and Services Administration (HRSA) grant funds), or other entity unless that service obligation will be completely satisfied before the SLRP contract has been signed? Yes ◯ No ◯

   Please note that certain provisions in employment contracts can create a service obligation (e.g., an employer offers a physician a recruitment bonus in return for the physician's agreement to work at that facility for a certain period of time or pay back the bonus).

2. Do you have: • Federal judgment liens. • A current default on any federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, federal income tax liabilities, Federal Housing Authority Loans, etc.) even if the creditor now considers them to be in good standing; • Breached a prior service obligation to the federal/state/local government or other entity, even if they subsequently satisfied the obligation; and • Had any federal or non-federal debt written off as uncollectible or received a waiver of any federal service or payment obligation? Yes ◯ No ◯

3. Do you practice full-time or half-time in providing primary health care services at an eligible site? Yes ◯ No ◯

4. Do you work in a practice site located in a federally designated Health Professional Shortage Area (HPSA) that corredsponds to your training and/or discipline? Yes ◯ No ◯
   For example, psychiatrists and other mental health care providers must serve in a mental health HPSA.

5. Do you agree to use SLRP funds only to repay qualifying educational loans? Yes ◯ No ◯
   Qualifying educational loans are Government and commercial loans for actual costs paid for tuition and reasonable educational and living expenses related to the education of the participant.

6. Is your practice site a for-profit health care facility? Yes ◯ No ◯

7. Does your health care practice site accept reimbursement from the following: Medicare, Medicaid, and the Children's Health Insurance Program? Yes ◯ No ◯

8. Does your health care practice site utilize a sliding fee scale and see all patients regardless of their ability to pay? Yes ◯ No ◯

9. Does the practice site charge for professional services at the usual and customary prevailing rates except free clinics? Yes ◯ No ◯

10. Does the practice site provide discounts for individuals with limited incomes (i.e., use a sliding fee scale)? Yes ◯ No ◯
    • For those with annual incomes at or below 100 percent of the HHS Poverty Guidelines, practice sites must provide services at no charge or at a nominal charge. • For individuals between 100 and 200 percent of the HHS Poverty Guidelines, practice sites must provide a schedule of discounts, which must reflect a nominal charge covered by a third party (either public or private).

11. Have you entered into an appropriate agreement with the South Dakota Department of Social Services that administers the State Plan for medical assistance under Medicaid to provide services to individuals entitled to medical assistance under the plan.

- ◯ Yes
- ◯ If no, please explain.

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 _____

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