

**KENTUCKY OFFICE OF RURAL HEALTH
UNIVERSITY OF KENTUCKY**

Provider Application for Kentucky State Loan Repayment Program

(Please type or print in blue or black ink)

1. _____ 2. _____
Name **Date (mm/dd/yyyy)**

3. _____ 4. _____ *5. **Gender:** M F
Social Security # **Date of Birth (mm/dd/yyyy)**

6. _____ 7. _____
Current Street Address **Current Mailing Address**

8. _____ 9. _____ 10. _____ 11. _____
City **State** **Zip** **County**

12. _____ 13. _____ 14. _____
Home Phone **Work Phone** **Email Address**

15. **Are You a U.S. Citizen:** Y N

*16. **Ethnicity:**
Hispanic/Latino
Not Hispanic/Latino

*17. **Race:**
American Indian
Alaska Native
Asian
Black or African American
Native Hawaiian
Other Pacific Islander
White

***This classification is being collected for presenting data on race, ethnicity, and gender for Federal reporting purposes only.**

18. **Type of Provider:**

<input type="checkbox"/> Family Practice Physician	<input type="checkbox"/> Psychiatric Nurse Specialist
<input type="checkbox"/> Internal Medicine Physician	<input type="checkbox"/> Marriage & Family Therapist
<input type="checkbox"/> Pediatric Physician	<input type="checkbox"/> Nurse Practitioner
<input type="checkbox"/> OB/GYN Physician	<input type="checkbox"/> Certified Nurse Midwife
<input type="checkbox"/> General Psychiatrist	<input type="checkbox"/> Certified Midwife
<input type="checkbox"/> Clinical Psychologist	<input type="checkbox"/> Physician Assistant
<input type="checkbox"/> Clinical Social Worker	<input type="checkbox"/> Dentist
<input type="checkbox"/> Licensed Professional Counselor	<input type="checkbox"/> Dental Hygienist

19. _____
Name of Professional School Attended

20. _____ 21. _____
Address **City** **State** **Zip** **Date of Graduation (mm/dd/yyyy)**

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22. _____
Name of Residency Program

23. _____ 24. _____
Address City State Zip Phone Number

25. **Are you Board Certified:** Y N

26. **Are you Board Eligible:** Y N

27. _____
Name of Board

28. _____
Date of Certification (mm/dd/yyyy)

29. **Describe your Residency or Program training experience outside the teaching hospital or professional school. Include experience in working with shortage area populations, rotations in rural and urban areas, nature and length of rotations.**

30. License Information:

Type: _____ **Date Issued (mm/dd/yyyy):** _____

State: _____ **Expiration (mm/dd/yyyy):** _____

Number: _____ **Restriction:** _____

31. **Has your license ever been restricted or revoked in any state?** Y N *(If yes, please explain)*

32. **Do you have any professional disciplinary actions pending in any state?** Y N *(If yes, please explain)*

33. **Do you have an existing service obligation with any Federal, State, or other entity?** Y N
(If yes, please describe the obligation and when it will be completed.)

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34. Are you delinquent on any child support payments? Y N

35. Are you in default or breach of contract for any student loans? Y N

36. Have you defaulted on any Federal debt or have a judgment lien against you arising from a federal debt?
 Y N (If yes, please explain)

37. Professional References:

Name **Phone**

Address **City** **State** **Zip**

Name **Phone**

Address **City** **State** **Zip**

Name **Phone**

Address **City** **State** **Zip**

38. I have signed or will sign an agreement with the following State Loan Repayment Program approved site to practice for two or more years. (Site must be approved by the Kentucky State Office of Rural Health)

Name of Site **County**

Address **City** **State** **Zip**

Name of Site contact **Phone**

To help us better assist you, please answer the following question.

39. How did you hear about the Kentucky State Loan Repayment Program?

- Website
- Friend
- Publication
- Other (specify) _____

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I understand that, if approved for a loan repayment, I must fulfill the following obligations:

- Practice (work full-time) in a Health Professional Shortage Area (HPSA) determined by the health care organization co-sponsoring the loan repayment for the duration of the loan repayment obligation;
- Will not, in the case of a patient seeking care, discriminate on the basis of the individual's ability to pay for care or on the basis that payment for care will be made pursuant to the programs established in Title XVIII or Title XIX of the Social Security Act;
- Accept assignment under section 1842(b)(3)(B)(ii) of the Social Security Act for all services for which payment may be made under Part B of Title XVIII of such Act, and will enter into an appropriate agreement with the state agency that administers the state plan for medical assistance under Title XIX of such Act to provide services to individuals entitled to medical assistance under the plan; and,
- The recipient will provide to the Kentucky State Loan Repayment Program a copy of his/her annual license certification renewal form and will report semi-annually by letter the name, location and nature of practice to the community organization(s). The report will include a copy of the agreement with the recipient under Title XVIII of the Social Security Act in which the recipient agrees to accept assignment of patients served under Title XVIII.

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 Kentucky State Office of Rural 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 willfully providing false information will result in disqualification from participation in this program.

Signature

Date (mm/dd/yyyy)

Printed Name