Physician Loan Repayment Program

APPLICATION

Note: There is *no deadline* to apply. However, the number of awards is dependent on the number of eligible applications and availability of funding.

Program Administrator
For additional information, please contact Uncommon Good
Phone: (909)625-2248 or Email: nmintie@uncommongood.org

APPLICANT INFORMATION		
Full Name		Date of Birth
Gender	Social Security #	
Ethnicity	Country of Origin	
Home Phone	Cell Phone	Work Phone
Personal Email		Work Email

EDUCATION

Type of Medical Degree

- ❑ Doctor of Medicine (MD, Dr.MuD, Dr.Med)
- ❑ Doctor of Osteopathic Medicine (DO)
- ❑ Other (please specify):________________________________

License Number

Name of school(s) from which your degree was received

Name	City/State	Graduation Date
Name	City/State	Graduation Date
Name	City/State	Graduation Date

Are you actively Board Certified in one of the following areas (check all that apply)?

- ❑ Internal Medicine
- ❑ Family Medicine
- ❑ Obstetrics & Gynecology
- ❑ Pediatrics

Are you committed to serving in L.A. Care's Medi-Cal Network for at least three years?

- ❑ Yes
- ❑ No

Are you fluent in a language or languages other than English?

- ❑ Yes
- ❑ No

If Yes, please indicate the language(s):

Do you speak medical Spanish?

- ❑ Yes
- ❑ No

EMPLOYMENT INFORMATION *(Please provide current employer information)*

Name		
Address		
City	State	Zip Code
Phone	Fax	Email
Date of Hire	Annual Salary	

Employment Status

- ❑ Full-time
- ❑ Part-time (Please indicate hours of direct patient care per week ________________)

Is your employer a contracted provider in L.A. Care's Medi-Cal network?

- ❑ Yes
- ❑ No

Is your employer a member of the Community Clinic Association of Los Angeles County (CCALAC)?

- ❑ Yes
- ❑ No

You may visit https://ccalac.org/ for more information.

Is your employer the Los Angeles County Department of Health Services (DHS)?

- ❑ Yes
- ❑ No

You may visit http://dhs.lacounty.gov/wps/portal/dhs for more information.

Employer national provider identifier (NPI) number:____

(The NPI number is a unique 10-digit identification number issued to covered health care providers by the CMS (Centers for Medicare and Medicaid Services)

Will you be providing direct patient care at more than one practice site?

- ❑ No
- ❑ Yes - If yes, please provide the following information for additional practice sites below

Elevating *The Safety Net*

An L.A. Care Health Plan Initiative to Strengthen the Provider Safety Net in L.A. County

Additional Practice Site #1		
Employer Name		
Site Address		
City	State	Zip Code
Site Phone Number	Site NPI Number	
Hours of Direct Patient Care per week		
Additional Practice Site #2		
Employer Name		
Site Address		
City	State	Zip Code
Site Phone Number	Site NPI Number	
Hours of direct patient care per week		
Employer Representative who can verify employment information: ***Note:*** The Program Administrator may contact your employer at any time during this award to verify application information.		
Name	Title	
Address		
City	State	Zip Code
Work Email		
Two Professional References		
Name		
Relationship to Applicant		
Employer		
Telephone	Email	
Name		
Relationship to Applicant		
Employer		
Telephone	Email	

EDUCATIONAL DEBT INFORMATION

IMPORTANT: For each loan listed, provide copies of the underlying loan documents and promissory note in your possession.

Loan 1	Account #	Lender Name
Phone #	Original Loan Amount	Current Loan Amount

Loan 2	Account #	Lender Name
Phone #	Original Loan Amount	Current Loan Amount

Loan 3	Account #	Lender Name
Phone #	Original Loan Amount	Current Loan Amount

Loan 4	Account #	Lender Name
Phone #	Original Loan Amount	Current Loan Amount

Attach additional sheets if necessary. Print your name at the top of any additional sheets.

OTHER LOAN REPAYMENT ASSISTANCE PROGRAM (LRAP) ELIGIBILITY AND PARTICIPATION

Please check the appropriate box and complete all questions asked.

- ❑ No, there is no other loan repayment program to which I can apply
- ❑ I am eligible for another LRAP, and…
  - ❑ I have applied to participate and am awaiting a response. I expect to receive notification by ____________________ (Month, day, year - or closest approximation).
  - ❑ I am going to apply or am in the process of applying. The application deadline is______________ (Month, day, year), and I expect to receive notification by __________________________ (Month, day, year - or closest approximation).
  - ❑ I applied to participate and was deemed eligible. I have been receiving, or expect to receive the following LRAP benefits.

Either attach a copy of award letter or promissory note from this program stating the amount you will receive and the timetable for receiving it, or describe this information below as specifically as possible. In particular, explain whether you will receive a sum toward your monthly debt repayment, a lump sum that will go toward your loan principal, or another form of assistance. (Attach additional sheets if necessary. Print your name at the top of any additional sheets.)

Type of program (school-based, employer, state, other):

____
____
____
____

Name of program and/or name of school, employer, state, etc. offering the program:

____
____
____
____

Name and phone number of contact person at the program:

____
____
____
____

APPLICANT PERSONAL STATEMENT

Please describe how you have demonstrated cultural sensitivity to your patient communities, a long-term interest in providing access to quality health care for vulnerable and low-income individuals and families, and leadership potential in the community health field. *(You may use additional pages if necessary).*

REQUIRED DOCUMENTS

- ❑ Completed Application
- ❑ Board Certifications
- ❑ Most recently filed tax return
- ❑ Proof of outstanding educational loan balances (i.e. loan statements)

APPLICANT SIGNATURE DISCLAIMER

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in my application being dismissed.

X ______________________________________

Applicant Signature:

Application Completion Date:___________________________