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

UncommonGood
Education Health Environment

Provider 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.

APPLICANT INFORMATION		
Full Name		Date of Birth
Gender	Social Security #	
Ethnicity	Country of Origin	
Personal 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):_____	**California Physician License Number**

Name of school(s) from which you received your medical degree(s)		
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
- ❑ Psychiatry

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

- ❑ Yes - please indicate language(s): _____
- ❑ No

Do you speak medical Spanish?

- ❑ Yes
- ❑ No

EMPLOYMENT INFORMATION

Name		
Corporate/Headquarter Address		Suite/Floor
City	State	Zip Code
Phone	Fax	Email
Date of Hire	Annual Salary	

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

- ❑ Yes
- ❑ No

EMPLOYER REPRESENTATIVE – Please state contact who can verify your hire date and hours of direct patient primary care at your practice site(s). **Note:** The Program Administrator may contact your employer at any time during the review and award process to verify application information and employment status updates.

Name	Title	
Address (including suite/floor)		
City	State	Zip Code
Work Email	Work Phone (include direct extension)	

PRACTICE SITE INFORMATION

Are you committed to serving in L.A. Care's Medi-Cal Network for at least three (3) years?

- ❑ Yes
- ❑ No

If you will provide direct patient care at more than one (1) practice site, please provide the following information for all individual practice sites below.

IMPORTANT NOTE: Each suite/floor is considered a practice site

Practice Site #1

Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #2		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #3		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #4		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

EDUCATIONAL DEBT INFORMATION

IMPORTANT NOTE: For each loan listed, please provide copies of the underlying loan documents and promissory notes. Please print your name at the top of any additional sheets.

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

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

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

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

OTHER LOAN REPAYMENT ASSISTANCE PROGRAM(S): Eligibility and Participation

Are you eligible and participating in other loan repayment assistance programs?

- ❑ Yes – please provide the information for each program in the section below
- ❑ No – there is no other loan repayment program to which I can apply

Loan Repayment Program #1

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

  Award Amount: $ _____

  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #2

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

  Award Amount: $ _____

  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #3	
Name of Program	Type of Program (school-based, employer, state,other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

  Award Amount: $ _____

  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

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

APPLICANT PERSONAL STATEMENT *(You may use additional pages if necessary)*

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.

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REQUIRED DOCUMENTS

- ❑ Completed Application
- ❑ Board Certifications (not required for program)
- ❑ Most recently filed tax return
- ❑ Proof of outstanding educational loan balances (i.e. loan statements)
- ❑ Other loan repayment assistance program award letter(s) or promissory note(s), if applicable

SUBMISSION PROCESS: Submit all materials via mail or e-mail to Program Administrator

MAIL	**EMAIL**
Uncommon Good 211 W. Foothill Blvd. Claremont, CA 91711 Attention: Nancy Mintie	nmintie@uncommongood.org Subject Line: Applicant's Name, Physician Loan Repayment Program Attention:Nancy Mintie

EMPLOYMENT AND CREDENTIALING VERIFICATION

Upon full review of your application and accompanying documents, the Program Administrator will provide an employment verification form to confirm employment and credentialing status.
Please note for continuity of award eligibility and disbursement, the employment verification form does not supersede the standard provider credentialing and facility site review process.

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.

Print and Sign Completed Application.
If submitting electronically, please scan and submit as PDF.

Applicant Signature : _____ Completion Date:_____

Program Administrator
For support, please contact Nancy Mintie, Executive Director, Uncommon Good
Phone: (909) 625-2248 or Email: nmintie@uncommongood.org