



Elevating The Safety Net

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



Provider Loan Repayment Program

APPLICATION

Note : There is no deadline to apply. However, applications are being accepted for the program's waitlist and will be considered when further funds become available. Moving forward, due to limited funding, the awarding process will be more selective and prioritize certain criteria (geographic areas, types of practices, areas of specialization, provider ethnic and cultural background, amount of debt, hours of direct patient care and demonstrated commitment to practicing in underserved communities), which are underfunded by the program.

APPLICANT INFORMATION		
Full Name	Date of Birth	
Address		
Gender	Social Security #	
Ethnicity	Birthplace (City and State)	
Personal Phone	Personal Email	
EDUCATION		
Type of Medical Degree <input type="checkbox"/> Doctor of Medicine (MD, Dr.MuD, Dr.Med) <input type="checkbox"/> Doctor of Osteopathic Medicine (DO) <input type="checkbox"/> 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
Name of institution(s) in which residency and/or fellowship training was completed		
Name	City/State	Completion Date
Name	City/State	Completion Date
Are you actively Board Certified or pursuing board certification in one of the following areas? (check all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Internal Medicine <input type="checkbox"/> Family Medicine <input type="checkbox"/> Obstetrics & Gynecology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Primary Care Psychiatry 		

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

Yes - please indicate language(s): _____

No

Do you speak Spanish

Yes

No

If you marked yes to the previous question, please mark your level of fluency?

Fluent

Conversational

Medical Spanish only.

EMPLOYMENT INFORMATION

Name

Corporate/Headquarter Address	Suite/Floor
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City	State	Zip Code
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Work Phone	Work Email
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Date of Hire	Annual Salary
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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
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Address (including suite/floor)

City	State	Zip Code
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Work Email	Work Phone (include direct extension)
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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	Service Planning Area (SPA)
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	Service Planning Area (SPA)
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	Service Planning Area (SPA)
<p>Prior to accepting employment from the employer you have listed in the Employment Information section of this application, have you worked for another employer providing primary care to the Los Angeles County Medi-Cal network?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p>If yes, please provide the name, address, and dates of employment for each of these employers:</p>		
Previous Employer Name	Previous Employer Address	
Dates of Employment		

Previous Employer Name		Previous Employer Address	
Dates of Employment			
Previous Employer Name		Previous Employer Address	
Dates of Employment			
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?			
<input type="checkbox"/> Yes – please provide the information for each program in the section below <input type="checkbox"/> 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	



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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.



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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

<p><u>MAIL</u> Uncommon Good 211 W. Foothill Blvd. Claremont, CA 91711 Attention: Francesca Twohy-Haines</p>	<p><u>EMAIL</u> ftwohy-haines@uncommongood.org Subject Line: Applicant's Name, Provider Loan Repayment Program Attention: Francesca Twohy-Haines</p>
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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 or my award withdrawn.

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

Applicant Signature: _____ Completion Date: _____

Program Administrator
 For support, please contact Francesca Twohy-Haines,
 Medicine for the Economically Disadvantaged Program Director, Uncommon Good
 Phone: (909) 625-2248 or Email: ftwohy-haines@uncommongood.org

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