Rural Communities Health Care Investment Program

Application Packet for Year 2007

Application Deadline: March 3, 2007

(Completed applications must be *POSTMARKED by the application deadline*.)

Contents

This Application Packet contains:

- Part A - Applicant Information
- Part B - Employment Verification
- Part C - Educational Loan and Lender Information
- Part D - Statement of Support
- List of qualifying counties

NOTE: Instructions for completion of all forms are located on the back of each form.

Mail application to:

Office of Rural Community Affairs
Attn: Brenda Copas
P.O. Box 1552
Vernon, TX 76385

Phone: (940) 553-3556
Fax: (940) 553-3560
Web: www.orca.state.tx.us

OFFICE ★ OF ★ RURAL
COMMUNITY ★ AFFAIRS

Where rural Texas comes first.

TEXAS STATE OFFICE OF RURAL HEALTH

Rural Communities Health Care Investment Program Requirements

Program Overview

The **Rural Communities Health Care Investment Program (RCHIP)** is a state-funded program for health professionals who practice in qualifying medically underserved communities in Texas. Awards are made on an annual basis, with this year's awards being made in May 2007. The number of awards is contingent upon the availability of funds. Health professionals who participate in the program must practice in a qualifying medically underserved or health professional shortage community. Communities located in a rural county are ranked as having a greater need for health professionals. Please be aware that loan applicants will be given priority over stipend applicants. Stipend applicants must be considered a newly recruited employee, within the last 6 months.

Qualifying Health Professionals – LOAN REIMBURSEMENT Program

Health professionals are eligible to register and apply to the program if they:

- ☐ Are a practicing provider of health care or health related services, other than a physician, who holds a license, certificate, registration, permit or other authorization
- ☐ Owe amounts for qualifying educational loans for receiving a post-secondary education
- ☐ Are a practicing health professional in good standing and authorized to practice in Texas
- ☐ Have worked for at least 12 consecutive months prior to application in a Texas county, with a population of 50,000 or less, and designated as a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) by the U.S. Department of Health and Human Services.

Qualifying Health Professionals - STIPEND Program

A health professional awarded a stipend must enter into a contractual agreement with the Office of Rural Community Affairs (ORCA), formally establishing the health professional's commitment to practice in the community for a year after the contract is signed. Stipend payments are made quarterly. Health professionals are eligible to register and apply to the program if they:

- ☐ Establish an office and residency in the medically underserved area before receiving any portion of the stipend
- ☐ Provide a written commitment of community support, which must be signed by a locally elected official
- ☐ Have not defaulted on any educational loans and do not have a service obligation to any entity
- ☐ Have not received and are not receiving assistance under any local, state, or federal educational loan repayment or incentive program

Maximum award can be up to $6000 per year, and $24,000 for four 12-month periods of service. First consideration for awards is given to rural (non-metropolitan) Texas counties with the highest need for health care providers, and health care providers applying for loan repayment. RCHIP awards ARE NOT automatically renewed and a new application is needed for each year applicant wishes to apply for award.

Qualifying Communities

A medically underserved community means a community that is located in a Texas county with a population of 50,000 or less and has been designated under state or federal law as a Health Professional Shortage Area (HPSA), or a Medically Underserved Area (MUA). Please reference attached list of qualifying counties.

Registration and Application Submission

The Office of Rural Community Affairs (ORCA) accepts application forms for the RCHIP. The front of this cover sheet shows ORCA's mailing address, phone number, FAX number, and e-mail address and the deadlines for registration forms and the application. **These materials must be POSTMARKED no later than the deadline dates shown. Faxed applications will not be accepted.**

**AN INDIVIDUAL MAY ONLY APPLY FOR THE LOAN REIMBURSEMENT OR THE STIPEND, NOT BOTH. ALSO, IF YOU ARE APPLYING FOR THE PHYSICIAN ASSISTANT LOAN REPAYMENT PROGRAM (PALRP) YOU WILL NOT BE ELIGIBLE FOR THE RCHIP!*

PROGRAM APPLICATION - PART A

Applicant Information (To be completed by all applicants)

TYPE OR PRINT ALL ENTRIES! Read instructions located on back of this form before completing.

1. Name: _____
   Last, First, Middle initial
2. Social Security Number:_____
3. Home mailing address:_____
   (P.O. Box or Street + Apartment number)
   City, State, Zip:_____County:_____
4. Home phone number: (_____)_____ Work phone number: (_____)_____
5. Email address:_____
6. Health Care Profession: _____
7. Texas License Number:_____ Issue date: ___/___/___
8. Have you ever been subject to professional disciplinary action? ☐ Yes ☐ No
9. Have you established an office and residency in the qualifying community? ☐ Yes ☐ No
10. Name of facility: _____
    Facility mailing address:_____
    City, State, Zip:_____County:_____
11. Dates of employment: ___/___/___ to ___/___/___
12. Did you receive any educational scholarships or loans with a service (practice) obligation? ☐ Yes ☐ No
13. Name of school attended:_____
14. Program start/end dates: _____ to _____
15. Graduation date:_____
16. Do you use telecommunications in your practice? ☐ Yes ☐ No
17. Are you eligible for any other state loan forgiveness, loan repayment, or stipend program? ☐ Yes ☐ No
18. Are you applying for loan repayment or stipend? _____

You must attach proof of your graduation from program
(copy of transcript or diploma), along with a copy of your license.

The above information is accurate and correct to the best of my knowledge and belief.

Applicant's typed name:_____ Date: ___/___/___

Applicant's signature:_____

NOTARY PUBLIC:

Notary's signature: _____

PROGRAM APPLICATION - PART A

General Instructions

The applicant completes Part A of the Program Application. The application *will not be processed* unless:

- all entries in Part A are typed or printed;
- every item is completed;
- requested documentation is attached;
- Part A is signed by the applicant; and
- a Notary Public has witnessed the applicant's signature.

Instructions

Items 1 - 3 - Self-explanatory.

Item 4 - Enter your home and work phone numbers including the area codes and any extensions.

Item 5 - Enter your email address.

Item 6 - Enter the type of health profession that you practice (e.g. registered nurse, chiropractor, etc.).

Item 7 - Enter the License Number that appears on your license and the date your license was *issued*.

Item 8 - Check the "yes" or "no" block to indicate whether or not you have been subject to professional disciplinary action.

Item 9 - Indicate whether or not you have established an office and residency in the community. (If you are applying for the stipend program and you have not established an office or residency, you are ineligible to apply.)

Item 10 - Enter the name of the facility and the facility's mailing addresses.

Item 11 - Enter the beginning date of the period during which you were employed at this facility. If you are still employed at this facility on the date you are completing this application, type "the present" in the second date space provided. If not, enter the date your employment terminated in the second date space.

Item 12 - Indicate whether or not you received any educational loans or scholarships that obligate you to service upon completion of your health care training. If you do have such a service obligation, you are ineligible to participate in the RCHIP.

Item 13 - Enter the name of the approved training program, which you completed.

Item 14 - Enter the start and end dates of your educational program.

Item 15 - Enter the date that you graduated from the training program.

Item 16 - Check the "yes" or "no" box to indicate if you use telecommunications in your practice.

Item 17 - Check the "yes" or "no" box to indicate if you are eligible for any other state funding programs.

Item 18 - Note if you are applying for Loan Repayment or Stipend.

Attach proof of your graduation from this program
such as a copy of your transcript or diploma.

Type or print your name and the date you are signing this form. Have your signature of this form witnessed by a Texas Notary Public.

PROGRAM APPLICATION - PART B

Employment Verification (To be completed by all applicants)

TYPE OR PRINT ALL ENTRIES! Read instructions on back of this form before completing.

SECTION I. Statement of Release (To be completed by the Applicant)

1. Applicant's name: _____
2. Applicant's Social Security number: _____
3. Applicant's mailing address: _____
   (P.O. Box or Street + Apartment number)
   City, State, Zip: _____ County: _____
4. Home phone number: (_____)_____ Work phone number: (_____)_____
5. Name of Personnel/Human Resources Administrator: _____
6. Administrator's mailing address: _____
   (P.O. Box or Street + Suite number)
   City, State, Zip: _____
7. Administrator's phone number: (_____)_____ Fax number: (_____)_____
8. Company/Agency name: _____
9. Applicant's signature: _____ Date: ___/___/___

By my signature, I authorize the employer named below to release information about my employment to ORCA.

SECTION II. Verification of Employment (To be completed by the Employer)

Read instructions on back of this form before completing.

The Health Care Professional named in Section I has applied to the Office of Rural Community Affairs for the Rural Communities Health Care Investment Program (RCHIP). Please provide the information requested below. Applicant: It is your responsibility to insure that your employer completes this section. You must forward the completed section with your completed application.

<u>If you are self employed, please see instructions</u>.

1. Employer's name (Company/Agency): _____
   Employer's mailing address: _____
   (P.O. Box or Street + Suite number)
   City, State, Zip: _____
2. This employer has employed the health professional named in SECTION I from: ___/___/___ to ___/___/___
3. Physical address of facility in which the health professional is employed:
   Employer's mailing address: _____
   (P.O. Box or Street + Suite number)
   City, State, Zip: _____
4. Average hours worked per week: _____
5. Are the hours reported in item 4 considered full-time? ☐ Yes ☐ No
6. County in which the facility is located: _____
7. Typed name of Personnel/Human Resources Administrator: _____
8. Signature of Administrator: _____ Date: ___/___/___

PROGRAM APPLICATION - PART B

Employment Verification

General Instructions

The ***Applicant completes Section I*** of this form and ***Employer completes Section II*** of this form. ***Except for the required signatures, all entries on this form must be typed or printed.***
Complete a separate Part B for each employer, if applicant has more than 1 employer. You may make additional copies of Part B form as needed.

Detailed Instructions

SECTION I - This section must be completed by the applicant.

Items 1 through 4 - Self-explanatory.

Item 5 - Enter the name of the person who handles all employee inquiries. This person may have a title other than "Personnel Administrator."

Items 6 through 9 - Self-explanatory.

SECTION II - This section must be completed by the applicant's employer.

Item 1 - Self-explanatory.

Item 2 - Enter the applicant's beginning date of employment. If the applicant is still employed on the date Section II is being completed, type "the present" in the second date space.

Item 3 - Enter the physical address of the facility in which the applicant is or was employed.

Item 4 & 5 - Self-explanatory

Item 6 - Enter the name of the county in which the facility is located.

Items 7 & 8 - Self-explanatory.

*For those individuals who are self-employed: You must attach proof of self-employment (business tax return, articles of incorporation, etc.) If proof of self-employment is not attached, *your application will not be processed*.

PROGRAM APPLICATION - PART C

Educational Loan and Lender Information

TYPE OR PRINT ALL ENTRIES! You may make additional copies of Part C form as needed. Read instructions on back of this form before completing.

SECTION I. Loan Information (To be completed by Applicant)

1. Type of loan: _____

2. Current balance: $ _____

3. Projected balance on September 1, 2007: $ _____

4. Account number: _____

5. Lender name: _____

   Lender mailing address: _____
   (P.O. Box or Street + Suite number)

   City, State, Zip: _____

   Lender phone number: (_____)_____ Lender fax number: (_____)_____

6. Servicer name (If different from Lender): _____

   Servicer mailing address: _____
   (P.O. Box or Street + Suite number)

   City, State, Zip: _____

   Servicer phone number: (_____)_____ Servicer fax number: (_____)_____

7. **Payments are made out to**: _____

Typed or printed name of Applicant: _____

Signature of Applicant: _____

Social Security Number: _____ Date: ___/___/___

PLEASE FILL OUT PART C FOR EACH LOAN THAT YOU HAVE. YOU MAY MAKE ADDITIONAL COPIES OF PART C FORM AS NEEDED.

**A COPY OF YOUR LATEST BILLING STATEMENT, SHOWING THE ENTIRE BALANCE FOR EACH LOAN, MUST BE ATTACHED OR YOUR APPLICATION WILL NOT BE PROCESSED.*

PROGRAM APPLICATION - PART C

Educational Loan and Lender Information

General Instructions

The applicant completes this form and returns it, with the rest of the application, to the Office of Rural Community Affairs. ***Complete one form for each account you want considered for repayment.*** You may make additional copies of Part C form as needed. Except for the required signatures, ***all entries on this form must be typed or printed.***

Detailed Instructions

SECTION I (To be completed by the applicant)

Item 1 - Enter the type of loan you received; for example, a Stafford Student Loan, a guaranteed student loan (GSL), Perkins loan, etc.

Item 2 - Enter the current total balance amount remaining due on the loan, as of the date you are completing this form.

Item 3 - Enter the total balance amount projected to remain on the loan as of September 1, 2007.

Item 4 - Enter the loan account number.

Item 5 - Self-explanatory.

Item 6 - Complete this item if the servicer of the loan is different from the lender.

Item 7 - **Enter the name of the entity to whom loan payments are made.**

Type or print your name and Social Security Number in the spaces provided, then sign and date the form in the spaces provided. Return the form, with the rest of the application, to the Office of Rural Community Affairs. A copy of your most current billing statement for each loan must be attached.

PROGRAM APPLICATION – PART D

Statement of Support (To be completed by Stipend applicants only)

Health Care Professional _____

Section I. Community Information (To be completed by Applicant)
TYPE OR PRINT ALL ENTRIES!

Community Information

1. City: _____

2. County: _____

3. County Population : _____

4. Elected Official Name: _____

   Title: _____

5. Phone Number: (_____)_____ Email_____

6. Applicants Type of Practice: _____

Section II. Statement of Support (To be completed and signed by elected official and applicant)

Statement of Support
The Community named above agrees to provide community support to the above-named Health Professional.

_____ Date: ___/___/___
Signature of Local Elected Official

_____ Date: ___/___/___
Title of Local Elected Official

The Health Professional named above agrees to practice in the above-named Community in the needed health care specialty. The Health Professional will practice in this Community for a minimum of one-year for the funds the Health Professional received from the Rural Communities Health Care Program (RCHIP). The Health Professional understands that failure to meet this service obligation will require cash repayment of the amount received and the imposition of severe financial penalties.

_____ Date: ___/___/___
Signature of Health Professional

PROGRAM APPLICATION – PART D

General Instructions

The applicant completes Section I of this form. An elected official and applicant complete Section II of this form.

Section I – This section must be completed by the applicant.

Items 1 through 3 – Self-explanatory.

Item 4 – Enter the name and title of the elected official who is providing the statement of support.

Item 5 – Enter the phone number of the elected official.

Item 6 – Enter the type of practice that you (Health Care Professional) have established.

Section II **– This section must be signed by the applicant and local elected official.**

The applicant and a local elected official must read and sign the statement of support.

QUALIFYING COUNTIES FOR THE RURAL COMMUNITIES HEALTH CARE INVESTMENT PROGRAM

Anderson
Baylor
Bee
Blanco
Borden
Bosque
Brewster
Briscoe
Brooks
Brown
Burnet
Camp
Cass
Castro
Childress
Cochran
Coke
Coleman
Collingsworth
Comanche
Cooke
Cottle
Crane
Crockett
Culberson
Dawson
Deaf Smith
DeWitt
Dickens
Dimmitt
Donley
Duval
Eastland
Edwards
Erath
Falls
Fannin
Fayette
Fisher
Floyd
Foard
Franklin
Freestone
Frio
Gaines
Garza
Glasscock
Gonzales
Grimes
Hall
Hamilton
Hansford
Hardeman
Harrison
Hartley
Haskell
Hill
Hockley
Hopkins
Houston
Howard
Hudspeth
Hutchinson
Jack
Jackson
Jeff Davis
Jim Hogg
Jim Wells
Karnes
Kenedy
Kent
Kerr
Kimble
King
Kinney
Kleberg
Lamar
Lamb
LaSalle
Lavaca
Lee
Leon
Limestone
Lipscomb
Live Oak
Llano
Loving
Lynn
McCulloch
McMullen
Madison
Marion
Mason
Matagorda
Maverick
Menard
Milam
Mills
Mitchell
Montague
Morris
Motley
Navarro
Newton
Nolan
Ochiltree
Oldham
Panola
Parmer
Pecos
Polk
Presidio
Rains
Real
Red River
Reeves
Refugio
Roberts
Runnels
Sabine
San Augustine
San Saba
Schleicher
Shackelford
Shelby
Sherman
Starr
Stephens
Sterling
Stonewall
Sutton
Swisher
Terrell
Terry
Throckmorton
Trinity
Tyler
Upton
Uvalde
Val Verde
Van Zandt
Walker
Ward
Washington
Wharton
Wilbarger
Willacy
Winkler
Wood
Yoakum
Young
Zapata
Zavala