# Health Professions Education Loan Repayment Application

HEALTH PROFESSIONS EDUCATION FOUNDATION

*Giving Golden Opportunities*

## Postmark Deadline: September 11, 2012

Application materials postmarked after the deadline will not be reviewed. Faxed copies will not be accepted.

## Giving Golden Opportunities by:

*Increasing the supply of Health Professions Educations practicing in medically underserved areas.*

*Awarding nurses who are dedicated to practicing in underserved communities.*

*Improving access to healthcare in rural and urban areas of California.*

*This program is funded by a grant from "The California Wellness Foundation"*

# HPLRP Application Instructions

The purpose of the Health Professions Education Loan Repayment Program (HPLRP) is to increase the number of Dentists, Dental Hygienist, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Clinical Nurse Specialists practicing in medically underserved areas of California (MUA). This is done by authorizing a plan for repayment of educational loans incurred while attending one of these health profession program. If awarded, the applicant agrees to provide direct patient care in a designated shortage area for a minimum of two (2) years.

Applications for the HPLRP are accepted annually and repay educational debt up to **$20,000.** The HPLRP is administered by the Health Professions Education Foundation (Foundation) and is funded by a grant from "The California Wellness Foundation". All awards are subject to the availability of funding.


**AM I ELIGIBLE?**

To be eligible for the HPE Loan Repayment, the applicant must:

- be currently licensed as a Dentists, Dental Hygienist, Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Clinical Nurse Specialists in California and in good standing with the respective boards,
- be practicing in an Medically Underserved Area (MUA), Health Professional Shortage Area (HPSA), County, State, prison or Veteran's facility (to find out if your facility qualifies please visit the Foundation's website for complete instructions at http://www.oshpd.ca.gov/HPEF/MUAs.html.),
- have outstanding educational debt from a commercial or U.S. government lending institution,
- NOT owe an existing service obligation,
- have valid legal presence and ability to work and provide care in the state of California, and
- submit a complete application that is postmarked on or before September 11, 2012.

**HOW DO I APPLY FOR THE LOAN REPAYMENT?**

For your application to be considered eligible for the HPLRP, each of the items listed below must be sent in and filled out completely. ALL MATERIALS MUST BE POSTMARKED BY THE DEADLINE. It is highly recommended that applicants submit their applications before the postmark deadline. The Foundation will ***not*** notify applicants if their application is received incomplete. No documentation of any kind will be accepted by fax or e-mail.

## Application and Document Checklist

| | |
|---|---|
| | **Completed Application:** Complete all entries and pages of this application. It must be completed, signed, and dated to be considered eligible. |
| | **Official Transcript with HP Degree Posted:** The transcript must be marked "official" by the school and show the HP degree conferred. The Foundation will not accept unofficial transcripts, copies or print outs of transcripts, or transcripts in an open/unsealed envelope. |
| | **Personal Statement**: Your statement must be typed and NO MORE THAN TWO (2) PAGES and must provide a comprehensive response to each question. Any pages submitted in excess of two pages will not be read or taken into consideration.<br><br>RESTATE AND NUMBER THE QUESTION ALONG WITH THE ANSWER. Personal Statements that lack detail may be considered incomplete and therefore, ineligible. |
| | **Two Letters of Recommendation:** Letters of recommendation must be **SIGNED** and **DATED** within **six (6) months** of the application deadline (between March 2012 and September 2012). The letters must be on letterhead or include the author's title, name of employer, mailing address, and phone number. It is recommended that at least one letter be from a supervisor. To receive maximum credit for community service, a letter from the agency where service was provided must be submitted. |
| | **Employment History:** Please list up to four health related employers. |
| | **Proof of HP License:** Enclose a copy of your California HP license. |
| | **Employment Verification Form (EVF)**: This form must be signed by a supervisor or administrative officer who can verify the applicant's employment. The EVF is enclosed as part of this application. |
| | **Signed 2011 Federal Tax Return and all W-2s**: DO NOT SUBMIT A STATE TAX RETURN. The State Tax Return will not be accepted in lieu of the Federal Tax Return. If filing jointly, please include a copy of your spouse's W-2s. |
| | **Lender Information Form/Lender Statements** Submit the attached Lender Information form and copies of your most recent (within six (6) months) lender statements with your name, the name of lender, balance owed, account number, and monthly payment amounts. All information on the form must be filled in and coincide with the information given on your lender statement or the application will be considered incomplete. |

This page does not need to be included with your application.

# Application Instructions

**WHAT IS THE SELECTION CRITERIA?**
Awards are made on a competitive basis. Selection for the HPLRP is based solely on information contained in the application and supporting documentation. Only complete applications will be evaluated.

Selection for awards is based on the following criteria:
- **Work Experience** - healthcare work experience in a MUA.
- **Cultural and Linguistic Competence** – the applicant's ability to understand and respond effectively to the cultural and linguistic needs of patients.
- **Financial Need** - actual or potential difficulty in paying educational debt in the absence of an award.
- **Career Goals** - short and long term professional goals as a HP.
- **Community Service** - documented volunteer service, memberships and/or community activities you have been involved in. If none, you are still eligible.
- **Background** - employment background, education, training or life experiences that influenced your commitment to becoming a nurse working with the underserved.
- **Fluency** - Although it is not a requirement to speak a second language, fluency in a language other than English must be verified on the Employment Verification Form.

## Glossary of Terms

**Direct Patient Care**: the provision of health care services directly to individuals being treated for, or suspected of having physical or mental illnesses. Direct patient care includes preventive care and first line supervision.

**Economically Disadvantaged:** a person whose gross family income at the time of application and the immediately preceding 2 years fell below 150 percent of the federally recognized poverty level.

**Full Time:** a minimum of 32 hours a week or its equivalent.

**Loan Repayment:** The Foundation is authorized to repay outstanding government and commercial educational loans for expenses related to the recipient's HP education that is required to practice as a HP (i.e., principal, interest, and related expenses for tuition, and educational expenses). Award recipients are responsible for making continued loan payments during the course of their participation in this program.

**Medically Underserved Area (MUA):** means any of the following:
a. A Medically Underserved Area or Medically Underserved Population (MUA or MUP) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
b. A Primary Care Health Professional Shortage Area (HPSA) as designated by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions' Shortage Designation Branch.
c. A California Primary Care Shortage Area as designated by the California Healthcare Workforce Policy Commission.
d. A facility determined by the Director pursuant to section 128385 of the Health and Safety Code to be an eligible county health facility or an eligible state-operated health facility.

**Service Obligation:** the contractual obligation agreed to by the recipient of a loan repayment where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.

## Frequently Asked Questions

**GENERAL**

**1. Do I have to be a permanent California resident and U.S. citizen to apply for the HPLRP?** Applicants must have a valid legal presence and ability to work and provide care in the state of California.

**2. How many applicants are awarded each cycle through the HPLRP?** The number of applicants awarded each cycle depends on the number of eligible HPLRP applications received as well as the availability of funding. Each cycle is unique and the Foundation staff cannot predict the number of award recipients.

**3. How is the HPLRP funded?** Supported entirely through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, and individuals. This cycle the HPLRP is funded by "The California Wellness Foundation"

**APPLYING FOR THE LOAN REPAYMENT**

**1. When is the deadline to turn in an application?** The annual postmark for the HPLRP is September 11. Make sure that the application you are using reflects the most current year. Updated applications are posted on our web site annually.

**2. Can I submit my application prior to the postmark deadlines?** You are encouraged to submit your HPLRP application six (6) weeks prior to the postmark deadline in order for Foundation staff to verify that your packet is complete. Any documents submitted beyond the postmark deadline will not be accepted. NO EXCEPTIONS.

**3. May I request an extension to file my application if I cannot obtain all the required documents by the postmark deadline?** No. All documents must be postmarked by the application due date. NO EXCEPTIONS.

This page does not need to be included with your application.

# Application Instructions

**4. Can my letters of recommendation be sent directly to the Foundation or do I need to include them with my HPLRP application?** You can either have your letters of recommendation sent directly to our office or you can submit them along with your application packet. However, it is the applicant's responsibility to ensure that all documents are SIGNED and DATED within six months of the deadline and postmarked by September 11, 2012.

**5. What is the maximum award amount for the HPLRP and am I guaranteed to receive this full amount?** The maximum award amount for the HPLRP is up to $20,000. Award recipients may not receive the full amount.

## ELIGIBILITY

**1. Who is eligible for an HPLRP?** Loan repayments are available to graduates and licensed health professionals in one of the following health professions: nurse practitioner, clinical nurse special, certified nurse midwifery, physician assistant, dental hygiene or dentistry and providing direct patient care in California and have educational debt.

**2. Can I still apply for the HPLRP if I currently owe an existing service obligation?** If you owe an existing service obligation to another entity, you are ineligible to apply with the Foundation until you have completed your existing obligation.

**3. Do I have to be bilingual in order to apply for the loan repayment?** No. You do not have to be bilingual in order to apply for the loan repayment.

**4. What do I do if my loans are consolidated?** If your loans are consolidated, you may list only the consolidated loans on the lender information section and also include the corresponding lender statements.

**5. What if my loans are in forbearance?** If your loans are in forbearance, you are still required to fill out the lender information and include a recent copy of corresponding lender statements.

**6. If I have been working in a qualified facility for several years already, can I backdate my contract to include time that I have already served?** No. You cannot use prior employment in order to complete the terms of your service obligation for the HPLRP. The start date of your two- to- four year service obligation will begin after you are awarded and will be identified in the contract.

## AFTER I'VE SUBMITTED MY APPLICATION

**1. When will I be notified whether or not I have been selected to receive an award?** The Foundation will notify applicants of the status their HPLRP application via e-mail periodically until awards are announced.

**2. If I am selected to be a loan repayment recipient, does the money come directly to me or will it be sent to my lender?** Checks will be issued directly to the lender on the recipient's behalf after the contract has been sent back to the Foundation.

**3. If I am selected to be a loan repayment recipient for the HPLRP, how many times can I reapply?** HPLRP recipients may receive up to $20,000 to repay educational debt paid over a two-year period committing to a two-year service obligation practicing in direct patient care in an MUA in California. However, there is no limit as to the number of times someone can apply. Note: Each loan repayment awarded requires a two-year service obligation for each contract.

**4. If I receive a loan repayment, is it likely I will receive a subsequent loan repayment?** Being a current recipient does not increase or decrease your likelihood to receive a subsequent loan repayment.

**5. If I am NOT selected to be a loan repayment recipient of the HPLRP and I reapply again, do I need to resubmit my entire application or can you reuse the materials I have already submitted?** HPLRP applicants must resubmit a complete application packet each time they apply. The Health Professions Education Foundation will not reuse or send back any documentation previously submitted.

## SIGNING A CONTRACT

**1. If I am selected to be a loan repayment recipient of the HPLRP, what are the terms of my contractual obligation?** All HPLRP award recipients are required to complete a two-year service obligation in a qualified facility providing direct patient care as a nurse practitioner, clinical nurse special, certified nurse midwifery, physician assistant, dental hygiene or dentistry.

**2. If I am selected to be a loan repayment recipient for the HPLRP, do I still have to make payments to my lender?** Yes. Award recipients are responsible for making continued loan payments to their lender throughout their participation in the HPLRP.

**3. If I am selected to be a loan repayment recipient for the HPLRP, do I still get paid my salary?** Yes. You will still get paid your salary if selected to receive a loan repayment award. Participation in the HPLRP does not affect your salary.

**4. What happens if I am unable to fulfill the terms of my contractual obligation and cannot complete my service obligation?** If an award recipient is unable to fulfill their contractual obligation, they will be required to repay all loan repayment funds received, plus ten percent (10%) interest.

**5. What happens if I need to change jobs during my service obligation?** You have the option to change jobs during the term of your service obligation. However, in order to comply with the terms of your contract, you must remain employed with a qualified facility.

DO NOT STAPLE APPLICATION

# HPLRP Application

- Please refer to the application instructions when completing the application.
- Complete all pages of the application and make sure all supporting documents are submitted with your application.
- All documents must be postmarked by the application deadline of **SEPTEMBER 11, 2012**.
- Late or incomplete application packets or documents will not be evaluated. No exceptions.
- Copies of pages requiring original ink signatures will not be accepted.

## PART A PERSONAL INFORMATION (Download and save this document to your computer.)

All personal and identifying information provided will remain private and confidential and will not be disclosed outside the HPLRP award process.

| | | | |
|---|---|---|---|
| Driver License or ID # | | *Social Security # | |
| Mr. ☐ | Mrs. ☐ | Ms. ☐ | Dr. ☐ |
| First Name | | Middle Initial | |
| Last Name | | | |
| Street Mailing Address | | | |
| City | | State | CA |
| Zip | | County | |
| Home Phone | | Cell Phone | |
| E-mail Address | | Re-enter e-mail address | |
| Date of Birth | | Male ☐ | Female ☐ |
| Number of dependents | | | |
| Do you have valid legal presence in the U.S.? | ◯ YES ◯ NO | Will you be providing direct patient care in CA? | ◯ YES ◯ NO |

Racial/Ethnicity: (Please choose one) Collected for statistical purposes only.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | African American | ☐ | Asian American | ☐ | Hispanic/Latino | ☐ | Native American |
| ☐ | Pacific Islander | ☐ | White/Caucasian | ☐ | Other (please specify) | | |

## PART B – QUESTIONNAIRE

| | | | |
|---|---|---|---|
| Do you currently owe an existing service obligation to another entity? **Please note: If you answer yes to this question, you do not qualify for this loan repayment.** | | ☐ YES | ☐ NO |
| Are you a prior awardee of the Foundation? If yes, please enter the contract # | | ☐ YES | ☐ NO |
| Are you the first in your family to attend college? | | ☐ YES | ☐ NO |

How did you hear about the HPLRP? (Check all that apply)

| | | | |
|---|---|---|---|
| ☐ | School | ☐ | Work |
| ☐ | Friend/Acquaintance | ☐ | Foundation Website |
| ☐ | Twitter | ☐ | Facebook |
| ☐ | Advertisement (please specify) | | |
| ☐ | Newspaper or Publication (please specify) | | |
| ☐ | Organization or Affiliation (please specify) | | |
| ☐ | Conference (please specify) | | |
| ☐ | Other Source (please specify) | | |

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012**

DO NOT STAPLE APPLICATION

Last Name:

First Name:

## PART C - LINGUISTIC COMPETENCY

1. List any languages in which you are fluent other than English. This must be verified by your employer on the Employment Verification Form.

| Language | | Language | |
|---|---|---|---|

## PART D - PERSONAL STATEMENT

Attach your personal statement to the application. Your statement must be typed and no more than two (2) pages. **Restate and number each question along with your answer**. Question 7 can be answered below. Personal statements that lack detail may be considered incomplete and therefore ineligible. Any pages submitted in excess of two pages will not be read or taken into consideration.

1. Describe how your employment background, education, training and life experiences have influenced your commitment to working in a medically underserved area.

2. Have you lived in an underserved or disadvantaged community? If so, please describe your experiences. If not, describe how you can relate to a community that is underserved or disadvantaged. Do you see your background as an advantage or disadvantage, or both?

3. After becoming a HP, describe your short term career goals (5 years) as it relates to providing direct patient care in a medically underserved area.

4. Describe your long term career goals (5+ years) as it relates to being a HP in a medically underserved area.

5. Give an example of how your life experiences and/or education have contributed to gaining an understanding of the cultural and linguistic needs of the medically underserved community.

6. Please tell us your reasons for applying for this loan repayment.

7. List any community service, volunteer activities and/or professional organizations that you have been involved in the past five years. If none, please leave blank. To receive maximum credit, please provide a letter or documentation of your involvement including contact information for the organization: name, address, and phone number.

| Community Service | Start/End Dates | Your Role | Was this paid or required by your employer? | |
|---|---|---|---|---|
| | | | ☐ Y | ☐ N |
| | | | ☐ Y | ☐ N |
| | | | ☐ Y | ☐ N |
| | | | ☐ Y | ☐ N |
| | | | ☐ Y | ☐ N |

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012**

DO NOT STAPLE APPLICATION

# Employment History

Last Name:

First Name:

Please list all your health related work experience. **List most recent employer first (maximum of 4 employers)**. All entries must be filled.

| | | | | | |
|---|---|---|---|---|---|
| 1. Employer's Name | | Street Address | | | |
| City | | State, Zip | | | |
| County | | Supervisor's Name | | | |
| Telephone Number | | E-mail | | | |
| Start Date | | End Date or PRESENT | | | |
| Your Position/Title | | Full Time | | Part Time | |
| | | Per Diem | | Volunteer | |
| Description of Duties | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 2. Employer's Name | | Street Address | | | |
| City | | State, Zip | | | |
| County | | Supervisor's Name | | | |
| Telephone Number | | E-mail | | | |
| Start Date | | End Date or PRESENT | | | |
| Your Position/Title | | Full Time | | Part Time | |
| | | Per Diem | | Volunteer | |
| Description of Duties | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 3. Employer's Name | | Street Address | | | |
| City | | State, Zip | | | |
| County | | Supervisor's Name | | | |
| Telephone Number | | E-mail | | | |
| Start Date | | End Date or PRESENT | | | |
| Your Position/Title | | Full Time | | Part Time | |
| | | Per Diem | | Volunteer | |
| Description of Duties | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| 4. Employer's Name | | Street Address | | | |
| City | | State, Zip | | | |
| County | | Supervisor's Name | | | |
| Telephone Number | | E-mail | | | |
| Start Date | | End Date or PRESENT | | | |
| Your Position/Title | | Full Time | | Part Time | |
| | | Per Diem | | Volunteer | |
| Description of Duties | | | | | |

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012**

DO NOT STAPLE APPLICATION

# Employment Verification Form

## THIS SECTION TO BE FILLED OUT BY APPLICANT

| | | | |
|---|---|---|---|
| Applicant's Last Name | First Name | MI | |
| Job Title | Employer Name | | |
| Employer's Address (no P.O. Boxes) | | | |
| City | State | CA | Zip |
| County | | | |

## THIS SECTION TO BE FILLED OUT BY YOUR DIRECT SUPERVISOR

ATTENTION! The completed form must bear an original ink signature. This section must be completed by the administrative officer or direct supervisor employed at the practice setting listed above. If this page is not SIGNED and DATED by the Administrative Officer or Supervisor, the application will be considered INCOMPLETE and INELIGIBLE. No copies or faxes will be accepted.

**1.** I understand that, should the applicant be awarded, I agree to sign Quarterly Reports that the employee is providing direct patient care as a HP until the service obligation is complete.

**2.** I declare under penalty of perjury that the information contained in this section is true and correct to the best of my knowledge.

| | | | | | |
|---|---|---|---|---|---|
| Start Date | | Full-time? | ○ | Part-time? | ○ |
| Average weekly hours worked | | | *Direct Patient Care hours per week or its equivalent | | |
| If called upon, the applicant uses the following language(s) in addition to English while in the work environment or within the community they serve: | | | | | |
| Language | | | Language | | |
| ONLY if applicant is considered a supervisor, please complete percentage of time below. I verify that the applicant's percentage of time is used as follows: | | | | | |
| % direct patient care | | % supervising | | % administration | |
| % other (please specify) | | | | | |

| | |
|---|---|
| Name (please print) | Title |
| Phone/Ext. | Fax |
| **Date** | **Signature** |

Tape Business Card On All Four Corners
DO NOT STAPLE

Signing Administrative Officer or Supervisor
***BUSINESS CARD REQUIRED***

☐ No card available

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012*

**Direct patient care" means the provision of healthcare services directly to individuals being treated for, or suspected of having physical or mental illness. Direct patient care includes preventive care. The first line supervision of direct patient care shall be considered direct patient care.*

DO NOT STAPLE APPLICATION

# Lender Information

Last Name:

First Name:

**Instructions**

1. All spaces must be completed on this form for each loan you have, ***even if the information appears on the lender statements that you provide***. Any missing information will make the application incomplete and ineligible.
2. All of the requested lender information below should correspond with the lending institution and location where your payments are processed. If additional pages are required, please include them with the application. If you have 5 or more loans, enter the ***total*** of all additional loans in the space where indicated below.
3. Submit current lender statements (dated within 6 months) for the educational debts listed below. They must include the current balance, account number, your name, the name of the lender, and address to which payment is submitted.

Total Educational Debt Owed: $

**NOTE: If you have more than 4 Loans, enter the information on a separate sheet. Enter the total for loans 5 and above here:**

| **LOAN 1** | | |
|---|---|---|
| Lending Institution | | |
| The name of the company/institution that you make your check payable to (if different than above) | | |
| Account Number | | |
| Lender's Payment Address | | |
| City | State | Zip |
| Outstanding Balance | | |

| **LOAN 2** | | |
|---|---|---|
| Lending Institution | | |
| The name of the company/institution that you make your check payable to (if different than above) | | |
| Account Number | | |
| Lender's Payment Address | | |
| City | State | Zip |
| Outstanding Balance | | |

| **LOAN 3** | | |
|---|---|---|
| Lending Institution | | |
| The name of the company/institution that you make your check payable to (if different than above) | | |
| Account Number | | |
| Lender's Payment Address | | |
| City | State | Zip |
| Outstanding Balance | | |

| **LOAN 4** | | |
|---|---|---|
| Lending Institution | | |
| The name of the company/institution that you make your check payable to (if different than above) | | |
| Account Number | | |
| Lender's Payment Address | | |
| City | State | Zip |
| Outstanding Balance | | |


DO NOT STAPLE APPLICATION

Last Name:

First Name:

## PART E – TWO LETTERS OF RECOMMENDATION

a. Must be **dated** and **signed** within the last **six (6) months** of the deadline date (March - September 2011).
b. Must be on letterhead or include the author's title, name of employer, mailing address, and phone number.
c. If any of these items are missing from the letter, it will be deemed incomplete and therefore, ineligible.

Please check one:

| | |
|---|---|
| ◯ | My two letters of recommendation comply with the instructions above and are included in my packet. |
| ◯ | My two letters of recommendation comply with the instructions above and will be sent by the postmark deadline of Sept. 11, 2012, separately to: HPLRP, 400 R Street, Suite 460, Sacramento, CA 95811. |

## PART F – OFFICIAL TRANSCRIPTS

a. Must be sealed and marked "Official" by the school(s).
b. Electronic submission must be sent from the school directly to the Foundation e-mail account: hpef-email@oshpd.ca.gov.

Please check one:

| | |
|---|---|
| ◯ | My official transcripts comply with the instructions above and are included in my packet. |
| ◯ | My official transcripts comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPLRP, 400 R Street, Suite 460, Sacramento, CA 95811. |
| ◯ | My official transcripts comply with the instructions above and will be e-mailed by the postmark deadline of Sept. 11, 2012, to the Foundation's e-mail at hpef-email@oshpd.ca.gov. |

## PART G – 2011 TAX RETURN AND ALL W-2'S

a. 2011 **Federal Tax Return** only (1040, 1040EZ, etc.).
b. You and your spouse's (if applicable) **signature** must appear on the tax return regardless of who prepared it or how it was filed.
c. If included on parents' tax statements, please submit those tax returns.
d. Include all **W-2's** or proof of income (1099).
e. If joint return filed, include both parties' W-2's and/or 1099.

☐ If self-employed, check this box (Tax Return are still required.)

☐ If you or joint party do not have W-2's, check this box and provide an explanation: _____

Please check one:

| | |
|---|---|
| ◯ | My signed 2011 Federal Tax returns and W-2's and/or 1099 comply with the instructions above and are included in my application packet. |
| ◯ | My signed 2011 Federal Tax returns and W-2's and/or 1099 comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012 to: HPLRP, 400 R Street, Suite 460, Sacramento, CA 95811. |

## PART H– PROOF OF LICENSE

a. Must be current and in good standing with the respective board.

Please check one:

| | |
|---|---|
| ◯ | I have included a copy of my current California license in my application packet. |
| ◯ | A copy of my current California license will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPLRP, 400 R Street, Suite 460, Sacramento, CA 95811. |

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012**

DO NOT STAPLE APPLICATION

Last Name:

First Name:

## PART I – LENDER STATEMENTS

a. All lender statement must be dated within the last six (6) months of the application deadline.
b. For consolidated loans, include proof of original loan source.
c. Any missing information will deem your application incomplete and therefore, ineligible.
d. Statement(s) must include the following:

| | | |
|---|---|---|
| Applicant Name | Lender's Name | Loan/Account Number |
| Current Address of applicant | Current Loan Payment Address | Current loan balance |

Please check one:

| | |
|---|---|
| ◯ | My lender statement(s) comply with the instructions above and are included in my application packet. |
| ◯ | My lender statement(s) comply with the instructions above and will be sent separately by the postmark deadline of Sept. 11, 2012, to: HPLRP, 400 R Street, Suite 460, Sacramento, CA 95811. |

## PART J – CONTACTS

List names, relationship, address, telephone numbers and e-mail of three (3) persons not living with you -- preferably relatives-- that will know how to reach you should the Foundation need to contact you immediately.

| | | |
|---|---|---|
| 1 | Name | |
| Relationship to applicant | | |
| Mailing Address | | |
| Phone | | E-mail |
| 2 | Name | |
| Relationship to applicant | | |
| Mailing Address | | |
| Phone | | E-mail |
| 3 | Name | |
| Relationship to applicant | | |
| Mailing address | | |
| Phone | | E-mail |

PERSONAL INFORMATION NOTIFICATION The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 14 of Title 22 of the California Code of Regulations, Sections 97701 et seq.) require every individual to furnish appropriate information for application to the Health Professions Education Loan Repayment Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Executive Director, Health Professions Education Foundation, 400 R Street, Suite 460, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

**Must be received by the postmarked deadline:**
**SEPTEMBER 11, 2012**

DO NOT STAPLE

Last Name:

First Name:

## PART K – INFORMATION RELEASE

I, the undersigned, authorize staff of the Office of Statewide Health Planning and Development/Health Professions Education Foundation (OSHPD/Foundation), to verify my education and employment in connection with the Health Professions Education Loan Repayment Program. I understand that the information to be provided will include information regarding my employment history and position status. Any information obtained through this release is to be kept confidential by the OSHPD/Foundation. This authorization is valid for five (5) years from the date of this form.

## PART L – APPLICATION CERTIFICATION

I certify that all information in this application is true and accurate to the best of my knowledge. I authorize the Health Professions Education Foundation (Foundation) to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application and the respective licensing Board will be notified. I understand that if falsification is discovered after I have been awarded or if I breach my contract, I will be required to repay all funds awarded, plus interest and administrative fees. I understand that once submitted, my application and supporting documents become the property of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

By signing this application, I acknowledge that I understand, if awarded the loan repayment, I will agree to the below terms:

- ✔ **attend a mandatory loan repayment contract orientation call**
- ✔ **return all correspondence in a timely manner**
- ✔ **notify the Foundation if there are any changes to name, lender, address, e-mail or employer**
- ✔ **be licensed in California**
- ✔ **fulfill a two-year service obligation at a qualified facility**
- ✔ **repay all funds received if I do not comply with the contract**

**Last Name:** _____ **First Name:** _____ **MI:** _____

**Applicant's Signature:** _____ **Date:** _____


**If you do not SIGN and DATE your application, it will be considered INCOMPLETE and INELIGIBLE. Send this ORIGINAL SIGNED AND DATED PAGE. Electronic signatures are NOT acceptable. No copies or faxes will be accepted.**

**Submit applications to:**
**Health Professions Education Foundation**
**ATTN: HPLRP**
**400 R Street, Suite 460**
**Sacramento, CA 95811**
**(800) 773-1669 or (916) 326-3640**

**PLEASE DO NOT STAPLE OR SUBMIT APPLICATIONS IN A LOOSE LEAF BINDER**

**Must be received by the postmarked deadline: SEPTEMBER 11, 2012**

This page does not need to be included with your application.

HEALTH PROFESSIONS
EDUCATION FOUNDATION
*Giving Golden Opportunities*

400 R Street, Suite 460
Sacramento, CA 95814
www.healthprofessions.ca.gov
(800)773-1669



For additional information please refer to the Foundation web site:
**www.healthprofessions.ca.gov**
**Twitter @HealthProfCAgov**
**www.facebook.com/CalHealthWorkforce**