

ATTACHMENT 2 – APPLICATION - Primary Care Service Corps (PCSC) Loan Repayment Program

New York State Department of Health • Office of Primary Care and Health Systems Management • Corning Tower, Room 1695 • Albany NY 12237 • sch_loan@health.ny.gov • (518) 473-7019 • Page 1 of 5

Before completing this form, please read the instructions in Attachment #1 for completing the application or access at the following website: <http://www.health.ny.gov/funding/>.

I. Applicant Information

a. Applicant Name: _____

b. Applicant Address: _____

c. Telephone: Home _____ Work _____

d. Date of Birth: ____/____/____ E-mail: _____

e. Applicant SSN: _____ - _____ - _____

f. Are you requesting an amendment to your current Primary Care Service Corps Contract (check one)?

Yes

No. **If yes, STOP: you will be contacted by the Department outside of this funding opportunity. You do not need to apply using this form.**

g. Check the one that applies to you:

I am a U.S. citizen

I am a permanent resident alien holding an I-155 or I-551 card

I am neither of the above: **STOP – you are not eligible to apply!**

h. Applicant’s Professional Discipline (Check one)

_____ Dentist

_____ Nurse practitioner

_____ Midwife

_____ Dental hygienist

_____ Clinical psychologist

_____ Licensed clinical social worker

_____ Marriage/family therapist

_____ Mental health counselor

_____ Physician assistant

If you are any other discipline than the above, **STOP - you are not eligible to apply!**

i. Applicant’s specialty/subspecialty: _____

j. Are you currently licensed, registered, and certified (if applicable) to practice your profession in New York State? Attach a photocopy of each, as applicable.

Yes, license number _____

Pending, date applied _____

No, not licensed or pending licensure. **STOP – you are not eligible to apply!**

Yes, registration number and expiration date _____

Pending, date applied _____

Yes, certificate number _____

Pending, date applied _____

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- k. Indicate all high schools, undergraduate/graduate schools, and internship/residency programs that you have attended, as well as dates attended, major or specialty, and degree awarded. Attach additional sheets as necessary.

Name and Address of Institution	Dates Attended (from/to)	Major or Specialty	Degree Awarded
1.			
2.			
3.			
4. Internship/Residency Program:			

- l. What languages, if any, do you speak fluently (in addition to English). Attach documentation:

II. Proposed Practice Site

- m. Please provide information about the employer and site(s) at which you propose to fulfill a service obligation under this program.

Site _____ of _____ total sites

Name: _____

Address: _____

Employer is: _____ Not-for-Profit _____ For-Profit

If employer is a for-profit entity, **STOP – you are not eligible to apply!**

- n. Date service will begin or began: _____ / _____ / _____ Date service will end: _____ / _____ / _____

If the beginning date service is prior to April 1, 2014, **STOP – you are not eligible to apply!**

Current or starting salary: \$ _____ per annum

Number of working weeks per year: _____

Weekly work hours at site listed in l. above (please complete table below):

Activity	Number of Weekly Work Hours
1. Direct primary patient care in ambulatory setting	
2. Teaching in ambulatory setting	
3. Practice-related administrative activities	
4. Clinical services in alternative setting (specify setting)	
5. Other activity (specify)	
6. Total weekly work hours	

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- o. Facility Type (Check one):
- | | |
|---|---|
| <input type="checkbox"/> FQHC/FQHC look-alike | <input type="checkbox"/> Critical access hospital (CAH) |
| <input type="checkbox"/> Outpatient mental health service | <input type="checkbox"/> Outpatient primary care clinic |
| <input type="checkbox"/> Outpatient oral health service | <input type="checkbox"/> School-based health clinic |
| <input type="checkbox"/> Tribal health clinic | <input type="checkbox"/> State correctional facility |
| <input type="checkbox"/> Solo/group private practice | <input type="checkbox"/> Other (specify) _____ |

- p. Is the facility operated by the following agency (check if yes)?
- | | |
|--|-------|
| New York State Department of Health | _____ |
| New York State Division of Veterans’ Affairs | _____ |
| New York State Office for Aging | _____ |
| New York State Office for People with Developmental Disabilities | _____ |
| New York State Office of Alcoholism and Substance Abuse Services | _____ |
| New York State Office of Children and Family Services | _____ |
| New York State Office of Temporary and Disability Assistance | _____ |
| Any federally-operated facility | _____ |

If you checked yes to ANY of these in o above, **STOP – you are not eligible to apply!**

- q. Is the proposed practice site located in a Health Professional Service Area (HPSA)?
- No Yes

If no, STOP – you are not eligible to apply!

If yes, indicate the name and ID No. of the applicable HPSA:

- r. Does the proposed site participate in Medicare, NYS Medicaid, and Children’s Health Insurance Program?
- No Yes

If no, STOP – you are not eligible to apply!

If yes, attach documentation as follows:

1. Twelve months of visit data summarizing by payer OR
2. Attestation by site principal that site participates in Medicare, NYS Medicaid and, if applicable, Children’s Health Insurance Program.

- s. Do the site and its parent organization, if applicable, promote a diverse work environment by attracting and hiring culturally diverse staff?

No Yes *(If yes, check all that apply; attach documentation for each item checked.)*

- _____ The site lists language skills or a bicultural background as a requirement for hiring in job descriptions;
- _____ The site places job announcements in non-English media;
- _____ The site sends job announcements to universities;
- _____ The site disseminates job announcements through local community groups;
- _____ The site highlights its organization’s mission in job announcements;
- _____ The site hires from within the local community;
- _____ The site offers incentives to bilingual employees;
- _____ The site hires interpreters who have completed local training programs;

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- The site works with local chapters of professional associations;
- Other activities.

t. Describe the methods by which the site accommodates patients of diverse ethnicities, the disabled, and other underserved populations (*See instructions. Attach additional pages as needed*):

III. Debt Information

u. List all loan debt for undergraduate or graduate education, made by or guaranteed by the federal or state government, or made by a lending or educational institution approved under Title IV of the Federal Higher Education Act. (Use additional sheets if necessary.)

Creditor Name	Creditor Address	Original Amount Borrowed	Current Balance
TOTAL			

v. Amount of funding requested from PCSC (not to exceed \$60,000): \$ _____

w. Requested term of contract (check one):

Full time (2 years – Maximum \$60,000)

Part-time (2 years – Maximum \$30,000)

Part-time (4 years – Maximum \$60,000)

Requested start date of service obligation: _____ / _____ / _____

IV. Participation in Loan Repayment or Scholarship Programs

x. Have you applied for or are you currently serving in any other government scholarship and/or loan forgiveness program?

No Yes If yes, please fill in boxes below, as applicable.

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Program Name	Award Received (Check one)	Award Amount	Date of Award (MM/DD/YYYY)	Length of Service Obligation (Months)
National Health Service Corps Scholarship	Yes No DP			
National Health Service Corps Loan Repayment Award	Yes No DP			
Other Program (Please specify):	Yes No DP			

(DP = decision pending)

y. Are you in breach of any current or past health professional service obligation under any of these programs?

No Yes

NOTE: If you checked “yes” in EITHER item x. or y. – **You may not be eligible to apply!**¹

V. Applicant Statement:

To the best of my knowledge, the information presented in this application is correct.

Signature: _____

Date: _____

VI. Please attach your employment contract for employment at the site(s) listed in item I above.

¹ NOTE: If you have applied for, but are not currently serving in, any other government scholarship and/or loan forgiveness program, you MAY still be eligible to apply for this program. Otherwise you are NOT eligible to apply. Please see Sections 3.3 and 3.4 of the Funding Opportunity document if you need clarification on this issue; or contact the Department at the email/phone listed above.