

Before completing this form, please read the instructions for completing the application at the following website:

http://www.health.ny.gov/professionals/doctors/graduate_medical_education/doctors_across_ny/

All applications must be submitted electronically to the New York State Department of Health by **July 31, 2015**, in **PDF format only** to gme@health.ny.gov

Select the program you are applying for (Check only ONE):

Physician Practice Support (PPS)

Physician Loan Repayment Program (PLR)

Period of Service Obligation: from _____ to _____

Section A. Applicant Information

1. Applicant Name _____

2. Applicant Address _____

3. Applicant's FEIN (facilities only) _____

4. NYSDOH Operating Certificate # (if applicable) _____

5. Person Completing this Application (Name & Title) _____

Phone _____ Email _____

6. Name, title, and signature of individual authorized to attest to the accuracy of the information in this application and to bind the applicant to any contract resulting from this application:

Name & Title _____

Signature _____

7. Applicant is Not for Profit For Profit (including Individual physicians)

8. Applicant Type (Check **one** category and appropriate region).

<input type="checkbox"/> Hospital or – Hospital Based Clinic	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State
<input type="checkbox"/> Diagnostic & Treatment Center	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State
<input type="checkbox"/> Group medical practice	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State
<input type="checkbox"/> Individual physician	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State
<input type="checkbox"/> Other health care facility	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State
<input type="checkbox"/> NYS OMH facility	<input type="checkbox"/> New York City	<input type="checkbox"/> Rest of State

Section B. Physician Information

For individual physician applicants, please complete on behalf of yourself.

1. Physician Name _____
2. Physician Address _____
- _____
3. Phone _____ 4. Email _____

5. A physician is eligible for this program **only if all 8 of the following pertain:**

- A U.S. citizen or permanent resident alien holding an I-155 or I-551 card;
- Licensed to practice in New York State by the time the service obligation begins;
- Not currently working in, or serving, an underserved area in New York State where the current service to the underserved area began prior to July 1, 2013;
- Not fulfilling an obligation under any state or federal loan repayment program where the obligation periods of the state or federal loan repayment program would overlap or coincide with the DANY obligation period, including any current DANY obligation;
- Not a past recipient of DANY Physician Practice Support or Physician Loan Repayment funding;
- In good standing with the Department of Health;¹
- Not be in breach of a health professional service obligation to federal, state or local government, or have any judgement liens arising from federal or state debt; and must not be delinquent in child support payments; and
- Working or plan to work in an eligible employment site listed on page 1 of the instructions.

The identified physician meets all of the following: Yes No

If the physician cannot meet all of the above, STOP. The physician is NOT eligible for DANY funding.

¹ i.e., not excluded from, or terminated by, the federal Medicare or Medicaid programs (see <http://www.omig.ny.gov/fraud/medicaid-terminations-and-exclusions>); not subject to Orders of the State Board for Professional Medical Conduct (see <http://w3.health.state.ny.us/opmc/factions.nsf/physiciansearch?openform>); or under indictment for, or convicted of, any crime as defined by New York State Penal Code (see <http://public.leginfo.state.ny.us/menuf.cgi>). Please note that the physician must have updated his or her mandatory Physician Profile (see <http://nydoctorprofile.com/>) information prior to the time of application.

6. Current Position Practicing/Attending physician
 Resident/Fellow *If physician is presently completing a residency, fellowship, or other medical training program, indicate the anticipated date of completion. _____ / _____*

7. Physician's start date of current employment: _____/_____/_____

8. Expected Start date of position for which applicant is requesting DANY funding: _____/_____/_____

Note: To be eligible for funding the physician must start the position and begin the State service obligation no later than 4/1/16.

9. Specialty: _____

10. Is identified physician currently licensed to practice as a physician in New York State?

- Yes, license number _____ Pending, date applied _____
 Currently in residency and has not yet obtained a license

11. If the identified physician has applied for or received any scholarships, loan forgiveness or other funds for the same or partially overlapping service obligation period for which he or she is applying in this application, insert the information in the table below.

	AMOUNT	DATE OF AWARD (if applicable)	DATES OF SERVICE OBLIGATION
Regents Health Care Scholarship	_____	_____	_____
National Health Service Corps Scholarship	_____	_____	_____
Regents Physician Loan Forgiveness Award Program	_____	_____	_____
National Health Service Corps Loan Repayment Award	_____	_____	_____
Doctors Across New York Physician Loan Repayment	_____	_____	_____
Doctors Across New York Physician Practice Support Loan Repayment Program – Other (Please specify):	_____	_____	_____

12. If applying for PPS or PLR funding for loan repayment, provide the physician debt information below (add a separate sheet if necessary):

CREDITOR NAME	CREDITOR ADDRESS	CURRENT BALANCE
_____	_____	_____
_____	_____	_____
_____	_____	_____
		TOTAL \$ _____

13. TOTAL DANY GRANT FUNDING AMOUNT REQUESTED (May not exceed \$150,000 for PLR or \$100,00 for PPS) \$ _____

Section C. Site Information If serving at more than one site, duplicate and complete relevant pages for each site. (see instructions)

Site ____ of ____

- 1. Name of Site _____
 - 2. Address _____

 - 3. Percentage of time spent at this site _____
 - 4. Location of area served by practice site Rural Inner City Suburban
 - 5. County(ies) served _____
 - 6. Town(s) served (if applicable) _____
 - 7. Neighborhood(s) served (if applicable) _____
 - 8. Population served (if applicable) _____
-

Section D. Proposed Specialty

- (a) If the physician will be practicing in General Internal Medicine, Family Practice, General Pediatrics, Geriatrics, OB/GYN, and Adult or Child Psychiatry in the geographic area served by the site(s) listed in this application; AND
- (b) the area or site is located in or serves one or more federally-designated Primary Care or Mental Health Professional Shortage Area(s) (HPSA) or Medically Underserved Area(s) (MUA); OR
- (c) is located in a rural town listed in the instructions, then check (a) and (b) or (c) below:

- a) General Internal Medicine, Family Practice, General Pediatrics, Geriatrics, OB/GYN, and Adult or Child Psychiatry
- b) HPSA/MUA and provide the number _____ and attach the printed page from the website
- c) Rural Area

Then skip Section E of this application.

- (d) For all other specialties, AND FOR PRIMARY CARE AND MENTAL HEALTH NOT PROVIDED in an HPSA or MUA or rural area check below.
- d) Primary Care/Mental Health Not in HPSA/MUA or Other Specialty

Section E. Identification of an Underserved Area

To be eligible for funding you must **check and document any 6 items** from the list below and **provide supporting documentation** for each item checked.

Proposed Service Area (from Section C)

1. The service area contains a high percentage of indigent persons demonstrated by (check any of the following):
 - a. A percentage of individuals below poverty level that exceeds 14.9% of the population of the service area (for non-NYC areas), or 19.9% for NYC) and/or
 - b. A median family income level lower than \$57,683, and/or
 - c. A per capita income level lower than \$32,104.
2. The service area contains _____% of non-white individuals, which is higher than the statewide average of 34.0%.
3. The service area contains _____% of employed persons, which is lower than the statewide average of 58.1% for persons in the civilian labor force (population 16 years and over)
4. The service area contains _____% children under age 5, which is higher than the statewide average of 6.0%.
5. The service area contains _____% of adults ages 65 or older, which is higher than the statewide average of 13.6%

Proposed Site

6. Twenty five percent (25%) or more of the site's (or if a hospital, department's) visits are for indigent care, i.e. Medicaid, Child Health Plus, free and sliding scale combined as a percentage of total visits.
7. **For primary care services only**, greater than 25% of all ED visits in the past four months to the hospital served by this site were for non-urgent care.
8. For rural health providers: Site is located in a rural town or county as listed in the instructions.
9. Average waiting time for **established** patients for **routine preventative or follow up** appointments with a primary care physician is _____ days, which exceeds seven (7) days from the initial patient request.
10. Average waiting time for **new** patients for **routine preventative** appointments with a **primary care** physician is _____ days, which exceeds fourteen (14) days from the initial patient request.
11. Average waiting time is greater than 48 hours for patients with urgent appointments or greater than 72 hours for patients with non-urgent "sick visit" appointments related to the specialty requested.
12. Search for a practice partner has not produced a physician in 12 months.

Proposed Specialty

13. Currently there are NO other providers offering similar services or there is insufficient capacity of providers for this specialty type at the proposed service site.
14. The travel distance from the applicant's proposed service site to the next closest provider practicing the listed specialty exceeds 20 miles (Rest of State) or 5 miles (NYC).
15. Site anticipates a decrease in the number of physicians practicing in the specialty due to announced or anticipated retirements or departures.
16. Site has employed 1 or more Locum Tenens to provide full time services in the proposed specialty for a minimum of 6 months in the past year.
17. For **specialty care**, county(ies) of proposed service area listed above is/are listed in Specialty Shortage Areas (see instructions).
18. For the hospital serving the site, (or the hospital itself if the applying site is a hospital) the rates of hospitalization for preventable conditions, or prevention quality indicators (PQI), exceed the statewide rate by 25% for the composite of conditions related to the specialty.

Section F. Employment Contract or Business Plan

Be sure to label your documents "Employment Contract" or "Business Plan."

- All Employment Contracts must be signed by the physician and the employer and reflect a two or five year service obligation period as described in the instructions.
- If the applicant is an individual physician requesting funds to join a practice, please insert a copy of the fully executed employment contract or partnership agreement.
- If the applicant is an individual physician requesting funds to start a practice, please insert a copy of a business plan as per the instructions.

Section G1. Budget Request for Individual Physician Applicants (Physician Practice Support Only)

COST CATEGORY	MONTHS 1-24	TOTAL FOR CATEGORY	JUSTIFICATION/EXPLANATION
Qualified Educational Loan Repayment	_____	_____	_____
Land/Building Acquisition/Rental	_____	_____	_____
Personnel Salaries	_____	_____	_____
Renovation/Construction	_____	_____	_____
Equipment/Furniture	_____	_____	_____
Investment in Partnership	_____	_____	_____
Other (specify):	_____	_____	_____
TOTAL	_____	_____	_____

Section G2. Budget Request for Facility or Practice Applicants (Physician Practice Support Only)

COST CATEGORY	MONTHS 1-24	TOTAL FOR CATEGORY	JUSTIFICATION/EXPLANATION
Income Guarantee	_____	_____	_____
Recruitment Bonus	_____	_____	_____
Productivity Bonus	_____	_____	_____
Relocation Reimbursement	_____	_____	_____
Continuing Medical Education Costs	_____	_____	_____
Other Cash Payment to Physician (specify):	_____	_____	_____
TOTAL	_____	_____	_____