



KANSAS STATE LOAN REPAYMENT PROGRAM

Health Care Practice Site Application

For more information: <http://www.kdheks.gov/olrh/FundLoan.html>

Email questions to: kdhe.primarycare@ks.gov

Health Care Professional Name: _____ Discipline: _____

Health Care Practice Site: _____

Legal Name of Health Care Practice Site (as it appears on Federal W-9 form):

This form must be completed by an authorized representative of the health care practice site and included with the *Health Care Professional Application* submitted by the health care professional for the State Loan Repayment Program (SLRP).

Please read the Kansas State Loan Repayment Program (SLRP) *Overview and Application Guidance* and *Frequently Asked Questions* documents in their entirety before completing this application or submitting questions regarding the SLRP. The application and attachments must be complete, typed or printed legibly, and submitted with the *Health Care Professional Application* between June 1 and July 31 of the application year. No early or late applications will be accepted. No incomplete applications will be accepted.

The health care professional applying for the SLRP must work a minimum of 40 hours per week, in no less than four days per week, 45 weeks per year, and provide at least 32 hours direct patient care each week at a non-profit or public entity which has met Kansas SLRP eligibility requirements (see *Overview and Application Guidance* document for exceptions to the 32 hours direct patient care requirement). If the health care professional works at multiple practice sites or satellite sites, **each** practice site must complete a separate *Health Care Practice Site Application* form.

ATTACHMENTS THAT MUST BE INCLUDED WITH APPLICATION

The following documents must be included with the *Health Care Practice Site Application* form. Failure to submit these documents will result in the application being incomplete and ineligible. All attachments should include the health care professional name and practice site at the top of each page and be labeled as PS Attachment #.

- PS Attachment 1 completed *Health Care Practice Site Application* form for each practice site
- PS Attachment 2 copy of health care professional's job description and employment contract
- PS Attachment 3 practice site policy on non-discrimination of patients based upon race, color, sex, national origin, disability, religion, age or sexual orientation
- PS Attachment 4 practice site policy for the sliding fee scale discount or financial assistance, and the patient application form for financial assistance
- PS Attachment 5 photograph of posted signage of the non-discrimination policy and sliding fee scale/ financial assistance policy
- PS Attachment 6 practice site proof of access/referral arrangements for ancillary, inpatient and specialty care that is not available on-site (MOUs, MOA, or contracts) If formal referral arrangements do not exist, describe how the practice site assures patient access to this care:

- PS Attachment 7 recruitment and retention plan and proposal to retain the health care professional upon completion of the service obligation
- PS Attachment 8 completed Federal W-9 form

HEALTH CARE PROFESSIONAL INFORMATION

Health Care Professional Name: _____ Discipline: _____

Employment Date: _____ Current/proposed salary: _____

Professional direct patient care hours per week: _____ Total hours professional works each week: _____

Average days worked each week: _____

Yes No Does the health care professional provide specialty care/services at this practice site?

If Yes, what specialty care services? _____

Yes No Is the health care professional under a service obligation or contractual commitment to serve at the practice site (i.e., a recruitment bonus in return for agreement to work at the practice site for a specified period of time or pay back the bonus)?

If Yes, date service commitment ends: _____

List benefits and malpractice coverage provided for this health care professional: _____

HEALTH CARE PRACTICE SITE INFORMATION

Health Care Practice Site: _____

Address: _____ City: _____ KS Zip: _____ + _____

Medical/Dental Director (name and title): _____

Primary Point of Contact (name and title): _____

Phone: _____ POC Email: _____

Federal Employer Identification Number: _____ DUNS & Bradstreet Number: _____

To find the HPSA score go to: <https://data.hrsa.gov/>

HPSA Type: Primary Care Dental Care Mental Health HPSA Score: _____

List practice site geographic boundaries or population centers served by the practice site: _____

Answer the following questions about the practice site.

Yes No Is the practice site a Federally Qualified Health Center (FQHC) or Look-a-Like (FQHC-LAL)?

Yes No Is the practice site a Rural Health Center (RHC)?

Yes No Is the practice site a Community Mental Health Center (CMHC)?

Yes No Is the practice site a public entity?

Yes No Is the practice site a non-profit entity?

Yes No Does the practice site accept patients regardless of insurance or ability pay?

Yes No Does the practice site accept **new** patients?

Yes No Does the practice site accept Medicaid/KanCare patients? Medicaid number: _____

- Yes No Does the practice site accept **new** Medicaid/KanCare patients?
- Yes No Does the practice site accept Medicare? Medicare number: _____
- Yes No Does the practice site accept **new** Medicare patients?
- Yes No Does the practice site offer a sliding fee scale or financial assistance to patients based on income?
- Yes No Does the practice site have a recruitment and retention plan in place?

On average, how many days does it take to schedule a routine, non-urgent appointment? _____

On average, how many days does it take to schedule a new patient routine, non-urgent appointment? _____

What percent of patients utilize the sliding fee scale/financial assistance? _____

Complete the practice site data for the previous calendar year in the tables below: Calendar year: _____

Payor Type	Number Unduplicated Patients*	Percent of Total Patients		Federal Poverty Level	Number Unduplicated Patients*	Percent of Total Patients
Medicaid/KanCare				0-100%		
Medicare				100-200%		
Private/Third Party Insurance				>200%		
Other Public				Unknown		
Uninsured						
Unknown						
Total Payor Type				Total FPL		

*Unduplicated Patients are defined as individuals who have at least one reportable visit during the report year.

Individuals with limited contact with the clinic should be excluded in the practice site data. Instances of limited contract would include, but are not limited to, persons whose only contact is:

- health care services provided as part of a large-scale effort, such as an immunization program, medical or dental screening program, or community-wide service program (i.e., health fair);
- health care professional is conducting outreach and/or group education, not providing direct care services; or
- when the only services provided are lab tests, x-rays, immunizations or other injections, TB tests or readings, and/or filling or refilling prescriptions.

See next page for signature block.

HEALTH CARE PRACTICE SITE SIGNATURE

I have read and understand the *Overview and Guidance Document* which describes the requirements of the Kansas State Loan Repayment Program (SLRP) and affirm that the practice site meets the qualifications for participation in the program. I understand that the information I have provided is subject to verification and providing willfully false information will result in disqualification from the SLRP.

I certify that the information provided is accurate and complete to the best of my knowledge.

Printed Name of Health Care Professional

Date

Signature of Health Care Professional

Printed Name of Authorized Practice Site Representative

Date

Signature of Authorized Practice Site Representative

Submit all documents to:

State Loan Repayment Program
Office of Primary Care and Rural Health
Bureau of Community Health Systems
1000 SW Jackson St, Suite 340
Topeka KS 66612-1365
Phone: 785-296-3135