Maryland Department of Health
Office of Oral Health

201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
410-767-3081

Maryland
DEPARTMENT OF HEALTH

Maryland Higher Education Commission
Office of Student Financial Assistance

6 N. Liberty Street
Baltimore, Maryland 21201
410-767-3300

PLEASE NOTE: *** The University of Maryland School of Dentistry is not an eligible worksite for this program. You may be eligible for the Health Resources and Services Administration National Health Service Corps Loan Repayment Program. Visit https://nhsc.hrsa.gov/loan-repayment for eligibility information.**

*** It is recommended that only those with higher education debt over the full award amount of $150,000 (Dentists)/ $20,000 (Dental Hygienists) apply due to the competitive nature of this award.**

Section A: Applicant Information

*** MDC-LARP awards are limited to one three-year award period for dentists/one two-year award period for dental hygienists. Previous recipients are not eligible for re-application.***

Last Name:	First Name:	MI:
Previous name under which records may have been kept:		
Address:		
City:	State:	Zip:
County:		(Home)
E-mail:		(Work)
		(Cell)
Social Security Number:		Date of Birth:
Maryland Dental/ Dental Hygiene License: YES ◯ NO ◯		License Number:

All valid Maryland dental/dental hygiene licenses are issued by the Maryland State Board of Dental Examiners

***** Must be Maryland Licensed by July 31, 2026 to be eligible for consideration. *****

Certification Statement

All the information on this application is true to the best of my knowledge. If asked by the Office of Student Financial Assistance or the Office of Oral Health, I will provide proof of the information I have given on this application.

I give permission for any information related to my application to the MDC-LARP to be shared with the members of the Review Panel in consideration for the MDC-LARP award.

Applicant Signature: _____ Date: _____

APPLICATION INSTRUCTIONS:

All application materials must be received and/or post marked by July 31, 2026.

Application documents should be completed electronically and submitted via email to: mdh.mdclarpprogram@maryland.gov

Please forward all questions regarding the application process to: mdh.mdclarpprogram@maryland.gov

Materials can also be faxed to (410) 333-7392, Attn. MDC-LARP, or sent to the following address:

MDC-LARP, Office of Oral Health
Maryland Department of Health
201 W. Preston Street, 4th Floor
Baltimore, MD 21201

Attn: Stacy Costello, MPH, CHES

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Section B: Additional Applicant Information

ALL items must be answered for form to be complete

	Yes	No
1. Are you a Maryland resident? **If Yes, how long? #Year(s):____#Months:____**	◯	◯
2. Are you a Medicaid provider currently? **If yes, what is your NPI Number? _____ Medicaid Number? _____**	◯	◯
3. Have you ever been charged or convicted of criminal activity other than a minor traffic violation? **If "Yes", please explain:**	◯	◯
4. Do you use illicit or illegal drugs?	◯	◯
5. Has your dental/dental hygiene license ever been suspended? **If "Yes", please provide the date suspended and state the reason why.**	◯	◯
6. Has your dental/dental hygiene license ever been revoked? **If "Yes", please provide the date revoked and state the reason why.**	◯	◯
7. Are you an ADA recognized specialist? **If "Yes", what specialty?**	◯	◯
8. Do you have hospital or operating room privileges? **If "Yes", where?**	◯	◯
9. Are you fluent in a language other than English? **If "Yes", please identify:**	◯	◯
10. Do you volunteer your services or expertise with any organization(s) in your community or abroad? **If "Yes", please list:**	◯	◯

Please list any professional affiliations:

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Section C: Dental/Dental Hygiene School Information

Dental/Dental Hygiene School:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		
Years practicing dentistry/dental hygiene:		

Section D: Other Educational Experience

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

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Section E: Practice Site Confirmation

Please provide information on the location(s) where you will be working if selected to participate in the program.

Total # of practice sites:_____ For all practice sites combined, **Total Annual Salary:** _____

Primary Practice:	Phone:
Start Date at Practice:	
# Clinical Hours Treating Patients Per Week:	
# Administrative Hours Per Week:	
Annual Salary | Compensation:	
Estimate your **CURRENT (**not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	**State:**	**Zip:**	**County:**

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Public Health Clinic:	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	◯	◯
Compensation for ALL practice sites:		

Secondary Practice:	Phone:
Start Date at Practice:	
# Hours/Week Treat Patients:	
Annual Salary | Compensation:	
Estimate your CURRENT (Not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	State:	Zip:	County:

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Public Health Clinic:	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	◯	◯

Tertiary Practice:	Phone:
Start Date at Practice:	
# Hours/Week Treat Patients:	
Annual Salary | Compensation:	
Estimate your CURRENT (Not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	State:	Zip:	County:

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Public Health Clinic:	◯	◯
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	◯	◯
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	◯	◯

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Section F: Employment History

Please list only relevant positions in reverse chronological order to coincide with current practice sites up to ten years.

Employer | Organization:		Phone:
Address:		
City:	State:	Zip:
Position:	Period of Service From:	To:
Reason for Leaving:		
Employer | Organization:		Phone:
Address:		
City:	State:	Zip:
Position:	Period of Service From:	To:
Reason for Leaving:		
Employer | Organization:		Phone:
Address:		
City:	State:	Zip:
Position:	Period of Service From:	To:
Reason for Leaving:		
Employer | Organization:		Phone:
Address:		
City:	State:	Zip:
Position:	Period of Service From:	To:
Reason for Leaving:		
Employer | Organization:		Phone:
Address:		
City:	State:	Zip:
Position:	Period of Service From:	To:
Reason for Leaving:		

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Section G: Educational Assistance History

	Yes	No
1. How did you hear about the Maryland Dent-Care Loan Assistance Repayment Program?		
2. Have you previously been awarded any other loan repayment? If "Yes", please name the program and describe the service agreement, including length of service and total $ amount of award.	◯	◯
3. Have you ever applied to the Maryland Dent-Care Loan Assistance Repayment Program? If "Yes", what year(s)?	◯	◯
4. Have you ever been offered an award from the Maryland Dent-Care Loan Assistance Repayment Program? If "Yes", what year(s)?	◯	◯
5. Are you currently obligated to any other agency for loan repayment or scholarships? If "Yes", please describe:	◯	◯
6. Have you EVER breached any service obligation(s), contract(s), etc.? If "Yes", what year(s) and are you in good standing now?	◯	◯
7. Have you EVER defaulted on an educational loan? If "Yes", what year(s) and are you in good standing now?	◯	◯
8. Are you CURRENTLY in default on an educational loan?*	◯	◯

*If you responded "Yes" to question 8 you are *not eligible* to apply for MDC-LARP.

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Section H: Personal Statement

The personal statement represents a significant portion of the candidate's application score.

Please use this section to provide an essay that briefly explains the following: (Only statements meeting specifications will be evaluated)

1. Describe why you are applying to MDC-LARP. Include professional/unique skills and knowledge you will bring to the program.
2. Describe the impact the MDC-LARP award would have on your life and clinical practice.

THE ABOVE TOPICS MUST BE ADDRESSED IN YOUR PERSONAL STATEMENT FOR CONSIDERATION

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Section I: Essay

The MDC-LARP application essay represents a significant portion of the candidates application score.

Please use this section to provide an essay on the following topic:

Describe your plan for sustaining and increasing your MMAP population beyond the service term.