2025 Application Cycle

MLRP APPLICATION PART I - Applicant Information

Maryland Loan Repayment Program

Application Deadline: April 15, 2025

Review and follow all application cycle instructions in order to meet submission requirements.

SAMPLE; NOT FOR SUBMISSION

Section 1: Applicant Information

1. Profession

2. Name

First MI Last

3. Social Security Number **4. Date of Birth**

5. Previous Name(s) Under Which Records Have Been Kept

Note: If all application documentation/uploads do not represent a consistent name, you must submit proof of name change (e.g., Marriage Certificate, Divorce decree, etc.).

6. Permanent Mailing Address

Address Line 1

City State Zip Code

7. Home Phone **Work Phone** **Mobile Phone**

8. Personal Email Address

Note: Provide a permanent personal email address that you consistently access as this address will be used throughout the application (and any potential award) process.

Section 2: Applicant Background and Demographics

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1. Gender

2. Are you Hispanic or Latino?

3. Race(s) (select all that apply)

☐ Asian ☐ Black/African American ☐ White/Caucasian

☐ American Indian/Alaskan Native ☐ Hawaiian/Other Pacific Islander

4. Are you a citizen/national of the United States?

5. Have you ever lived in a rural area, a geographical area located in a non-metropolitan county, or an area located in a metropolitan county designated by the Federal Office of Rural Health Policy as rural?

○ Yes ○ No

Am I Rural? Tool

6. Do any of the following apply to your background?

a. Environmentally Disadvantaged: A person's environment inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school.

○ Yes ○ No

b. Economically Disadvantaged: A person from a family with an annual income below a level based on low-income thresholds, according to family size established by the U.S. Census Bureau.

○ Yes ○ No

c. Educationally Disadvantaged: A person who comes from a social, cultural, or educational environment that has demonstrably and directly inhibited the person from obtaining the knowledge, skills, and abilities necessary to develop and participate in a health professions education or training program.

○ Yes ○ No

7. Have you ever served on active duty in the United States Armed Forces, either in the regular military or in a National Guard or military reserve unit?

○ Yes ○ No

Section 3: Applicant Obligation History

1. Have you ever been disciplined, suspended or dismissed by administrative, military, or other authorities?

○ Yes ○ No

2. Have you ever breached an obligation for service to any entity (e.g. federal, state, or local government or private) even if the obligation was ultimately paid in full?

○ Yes ○ No

3. Do you have a judgment lien against your property for a debt to any entity (e.g. federal, state, local, or private entity)?

○ Yes ○ No

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4. Have you ever been excluded, debarred, suspended, or disqualified by any entity (e.g. federal, state, or local government or private)?
○ Yes ○ No

5. Are you now or have you ever been in default on any eligible higher education loan?
○ Yes ○ No

6. Have you ever had any debts written off as uncollectible, including, but not limited to, home foreclosure, rent bills, credit card debt, etc.?
○ Yes ○ No

7. Have you ever had any service or payment obligation waived?
○ Yes ○ No

8. Have you ever violated court-ordered child support or been delinquent in child support payments?
○ Yes ○ No

9. Have you ever been convicted of a felony?
○ Yes ○ No

10. Do you have any unserved obligation(s) for service to a federal, state, local government, or other entity, with the exception of the U.S. Department of Health and Human Services Primary Care Loans, Exceptional Financial Need Scholarships, and Financial Assistance for Disadvantaged Health Professions Students?
○ Yes ○ No

11. Do you have any existing or future service obligations with any other program or employer, including, but not limited to, loan repayment, sign on bonus, retention bonus, etc.?
○ Yes ○ No
Note: Your contract/employment agreement will be reviewed to confirm this attestation. You may not have any existing or future employer obligations for any period of potential MLRP service obligation.

12. Have you applied for any other loan assistance repayment programs?
○ Yes ○ No

13. Have you previously been awarded loan repayment assistance?
○ Yes ○ No

Section 4: Medical or Nursing School/Training Program Information

1. Name of School or Training Program

2. Address

Address Line 1

City State Zip Code

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3. Date of Graduation

4. Degree/Certification Earned

5. Awards/Fellowships/Certificates Earned

6. Are you a graduated AHEC Scholar?
○ Yes ○ No

7. Do you have specific training and credentials to provide evidence-based substance use disorder (SUD) treatment and counseling?
○ Yes ○ No

8. Do you have a SUD License or Certificate issued by the state or a national credentialing organization?
○ Yes ○ No

9. Are you a Data 2000 Waiver Provider?
○ Yes ○ No

Section 5. Medical Residency (if applicable)

1. Name of Institution/Agency

2. Address

Address Line 1

City | State | Zip Code

3. Specialty or Sub-specialty

4. Date Residency Began

5. Date Residency Completed

6. Did you complete a community-based rotation in medical school or residency?
○ Yes ○ No

Section 6: Maryland Medical or Nursing License/Certificate

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Information

○ I have a Maryland License/Certificate

○ I have a License from another state that permits me to practice in Maryland (compact licensure)

○ I do not have a Maryland License/Certificate

State(s) of Current Unrestricted Licensure

Have you ever had a clinical license/certificate revoked or suspended?
○ Yes ○ No

NPI Number (if applicable)

Section 7: Educational Loan Debt

- Complete one section for each lender and each account number to represent educational loan debt obtained for the pursuit of the certification or licensure to be used during any potential service obligation resulting from this application. Any educational loans obtained beyond certification/licensure requirements are not eligible for loan repayment assistance and should not be included here.
- If you have more than one account number with a particular lender, please complete one section for each loan account number. Do not enter account series (e.g. 01234-A, 01234-B, 01234-C) as separate entries.
- The amount of loans and a combined figure will auto-sum at the bottom of the page.

Please note that lender statements are required to verify information provided.

Lender 1

Lender **Account Number**

Month/Year Loan goes/went into Repayment

Month **Year** **Current Outstanding Balance**

Loan Origination Date **For what degree did this loan pay?**

Monthly Payment **Has this loan been consolidated?**
○ Yes ○ No

Lender 2

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Lender

Account Number

Month/Year Loan goes/went into Repayment

Month

Year

Current Outstanding Balance

Loan Origination Date

For what degree did this loan pay?

Monthly Payment

Has this loan been consolidated?
○ Yes ○ No

Lender 3

Lender

Account Number

Month/Year Loan goes/went into Repayment

Month

Year

Current Outstanding Balance

Loan Origination Date

For what degree did this loan pay?

Monthly Payment

Has this loan been consolidated?
○ Yes ○ No

☐ **Add Lenders**

Total Loan Amount
$0.00

Section 8: Practice Site Information

1. Employer Name

2. Is this a public or non-profit (501(c)(3)) entity?
○ Yes ○ No
Note: Per authorizing statute, Nurses and Nursing Support Staff must be employed by a public or non-profit entity.

3. Practice Name

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4. Address

Address Line 1

City | State | Zip Code

5. Name of Practice Site Administrator that will Submit Part 2 of the MLRP Application on your Behalf

First | Last

Practice Site Administrator Email

Note: This individual/ email address will receive the request to complete the Employer Contribution to your application. Ensure that an accurate email address for the appropriate contact has been entered prior to submission.

6. Is this a new practice site for you?
○ Yes ○ No

7. Do you have additional practice sites?
○ Yes ○ No

8. Is the site/employer willing to support you in this endeavor?
○ Yes ○ No

MLRP participants who work part-time (20-39 hours per week), are automatically part-time program participants. MLRP participants who work full-time (40 hours per week) can be part-time or full-time program participants.

9. Are you applying for full-time or part-time program participation?
○ Full-time (40 hours per week) ○ Part-time (20-39 hours per week)

10. How many hours per week will you be working as a program participant?

Program hours per week you will work

11. How many hours per week will you provide direct patient care?

Hours of direct patient care per week

12. Do you provide Medication Assisted Treatment (MAT) Services at this time?
○ Yes ○ No

13. Which of the following services are you engaged in?

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☐ COVID-19 Treatment or Prevention Services

☐ Integrated Behavioral Health in Primary Care Services

☐ Substance Use Treatment Services

☐ Telehealth Services

☐ None of the Above

***Note**: Hours worked per week will be verified by the employment agreement submitted by your employer. A minimum of 40 guaranteed hours of work per week must be represented in the employment verification to be considered for full-time program participation. Employers may provide additional documentation to show hours worked via timesheets and/or pay stubs, for example, if the time is not accurately reflected in current employment agreements.*

Submission of the Part I will trigger email communication to your practice site contacts, who have until April 15 to complete their contribution to your MLRP application. You are strongly encouraged to communicate the application instructions and deadlines clearly with your application contributors, following-up to ensure complete and on-time submissions, as appropriate. Late and/or incomplete applications will not be eligible for program consideration.

Section 9: Personal Statements

1. Describe your commitment to working in an underserved area.

2. Describe how practicing in an underserved area will contribute to your long-term goals.

3. Describe the impact that a Maryland Loan Repayment Programs award would have on your life and clinical practice.

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4. How long do you intend to practice in an underserved area?
○ 2 years ○ 3 years ○ 4 years ○ >4 years

Section 10: Professional References

Submission of the Part I will trigger email communication to your professional references, who have until **April 15** to complete their contribution to your MLRP application.

You are strongly encouraged to communicate the application instructions and deadlines clearly with your application contributors, following-up to ensure complete and on-time submissions, as appropriate. Late and/or incomplete applications will not be eligible for program consideration.

Note: The individuals/email addresses noted below will receive the request to complete the Professional References for your application. Ensure that accurate email addresses for the appropriate contacts have been entered prior to submission.

1. Name **Job Title** **Email**

First

Last

2. Name **Job Title** **Email**

First

Last

3. Name **Job Title** **Email**

First

Last

Section 11: Attachments

Remember to attach required documents with Part I of the application: proof of citizenship, proof of malpractice insurance, and a copy of Maryland medical or nursing license.

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Proof of US Citizenship or Naturalization
Proof could include a birth certificate, U.S. passport, or naturalization documentation. The following do NOT provide proof of citizenship: Social security cards, driver's license documents.

Proof of Name Change
If all documentation does not represent a consistent name, you must submit proof of name change (e.g. Marriage Certificate, Divorce Decree, etc.).

Educational Loan Statement(s)
Educational loans noted in this application must be verified via submission of documentation from your educational loan lender(s). For each loan noted in Section 7, submit official lender documentation (such as a monthly balance statement) that includes the lender's name, address and phone number; borrower's name and account numbers; original loan balances; and current outstanding loan balances. All documentation must be dated within 60 days of application submission.

Proof of Malpractice Insurance/Certificate of Liability
Physicians, Advanced Practice Registered Nurses, Physician Assistants

Copy of Maryland Medical or Nursing License/Certificate

Section 12: Attestations and Signature

☐ **I attest that all of the information in this application is true and a comprehensive representation. If asked by the Maryland Loan Repayment Programs (MLRP), I will provide further proof of the information I have given in this application. Failure to do so by stated deadlines will result in ineligibility for the program this application cycle.**

☐ **I understand that I may only accept one service obligation if any are offered to me. I will contact MLRP if I decide to accept an award with another program and I will withdraw my application.**

☐ **I understand that MLRP participants are required to complete 6 (six) hours and submit proof of continuing education credit in cultural, linguistic, and/or health literacy competency as part of the annual conditions of award and this requirement is not connected to licensure-required Implicit Bias Training and will be required regardless of past completion of the licensure-required training. I have read and understand the Cultural Competency Training document associated with this program and application process, which also includes requirements of my practice site(s) (Part IV).**
Note: Part IV can be found here.

☐ **I understand that MLRP participants are required to participate in the gathering of experience, impact, and retention data requirements. I have read and understand the Experience, Impact, and Retention Data Requirements document associated with this program and application process which also includes requirements of my practice site(s) (Part V).**
Note: Part V can be found here.

☐ **I understand that MLRP loan repayment assistance is offered/awarded based on applicant eligibility, technical scoring based on State and Federal priorities, and the availability of funding. The application process is competitive. Application and award determinations made by the Maryland Department of Health are final.**

☐ **If I am offered and accept an MLRP service obligation, I understand the eligibility criteria for meeting the service obligation. I have read and understand the Maryland Loan Repayment Programs: Program Guidelines document, inclusive of Section E., Breach of Service Obligation.**
Note: MLRP Program Guidelines can be found here. (https://health.maryland.gov/pophealth/Documents/MLARP/Participant%20Docs/MLRP-Guidelines-7-2024.pdf)

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☐ **By signing this certification form, I am allowing my employer, professional references, and affiliated education loan lender(s) to disclose the information required to process this application. I am also permitting the use of my name and other limited information to be shared with the Maryland Department of Health and U.S. Human Resources and Services Administration as an MLRP applicant.**

Signature

Name **Date**

First MI Last Suffix

By clicking Submit, you are submitting your MLRP application to the Maryland Department of Health. At that time, no additional edits can be made to the Part I submission. Submission triggers automatic email messages to be sent to your noted employer(s) and professional references requesting their contributions to your MLRP application.

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