Maryland
DEPARTMENT OF HEALTH

MLRP APPLICATION PART I - Applicant Information

Maryland Loan Repayment Program

Application Deadline: April 15, 2024

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

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

6. Permanent Mailing Address

Address Line 1

City | State | Zip Code

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

8. Personal Email Address

Section 2: Applicant Background and Demographics

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 the United States or Maryland?
○ Yes ○ No

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?
○ 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 (e.g. loan repayment, sign on bonus, etc.) with any other program or employer?
○ Yes ○ No

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

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 Information

○ I have a Maryland License/Certificate

○ 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 Due Date (Day) **Monthly Payment** **Has this loan been consolidated?**
○ Yes ○ No

Lender 2

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 Due Date (Day) | **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 Due Date (Day) | **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. Practice Name

3. Address

Address Line 1

City | State | Zip Code

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

Behalf

First | Last

Practice Site Administrator Email

5. Is this a public or non-profit (501(c)(3)) entity?
○ Yes ○ No
Note: Only non-profit entities are eligible to be practice sites for nurses and nursing support staff.

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?
☐ 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.*

Submission of the Part I will trigger email communication to your practice site contacts, who have until May 1, 2024 to complete their contribution to your 2024 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.

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 **May 1, 2024** to complete their contribution to your 2024 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.

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.

Proof of US Citizenship or Naturalization

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
Physicians, Advanced Practice Registered Nurses, Physician Assistants

Copy of Maryland Medical or Nursing License/Certificate

Cultural Competency Requirements (Part IV)
Template available at: https://health.maryland.gov/pophealth/Pages/State-Loan-Repayment-Program.aspx.

Form only requires applicant signature at this time. Employer will provide a copy with their signature as required with MLRP Application Part II.

Experience, Impact, and Retention Data Requirements (Part V)
Template available at: https://health.maryland.gov/pophealth/Pages/State-Loan-Repayment-Program.aspx.

Form only requires applicant signature at this time. Employer will provide a copy with their signature as

required with MLRP Application Part II.

Section 12: 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 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 MLRP Understanding Breach of Contract document (Part VI).

☐ 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.