

Provider Application
Kansas State Loan Repayment Program

This application form is used to determine health professional eligibility for participation in the Kansas State Loan Repayment Program (SLRP). If you need additional space to answer any of the questions, attach as many pages as needed: type your name, license number, and service site at the top of each page.

Please provide along with this application a copy of the service site's sliding scale fee structure and the health professional's job description and contract or employment agreement, proof of citizenship and a copy of health professional's professional license.

1. Applicant information

Name (Last, First, Middle) _____, _____, _____

Social Security Number _____ - _____ - _____ US Citizen Yes _____ No _____

Date of Birth _____ Email _____

Address _____

City _____ State _____ Zip _____ County _____

Home Phone _____ Work Phone _____

Are you fluent in languages other than English _____ If yes, please specify _____

Do you possess experience or training in multicultural settings or serving populations with special needs?

(Please Describe) _____

Are you a native of a rural or underserved area, or have you spent a significant amount of time living or working in such an area? (Please Describe) _____

Race/Ethnicity (used for Federal Reporting Purposes only) White ___ Asian ___ Black/African-American ___
Hispanic or Latino ___ American Indian/Alaskan Native ___ Native Hawaiian/Pacific Islander ___

Sex (used for Federal Reporting Purposes only) Male ___ Female ___

2. Licensure Information

Type _____ Number _____

Date Issued _____ Expiration Date _____

Discipline/Specialty _____ Restrictions _____

Licensing Agency or Board _____

If you are not currently licensed in Kansas, when will you obtain Kansas licensure? _____

3. Education

Undergraduate School _____ Degree _____

Date of Degree _____ City, State _____

Graduate/Professional School _____ Degree _____

Date of Degree _____ City, State _____

Residency Site _____

Dates _____ City, State _____

Internship Site _____

Dates _____ City, State _____

Preceptorship Site _____

Dates _____ City, State _____

4. Service Site Information:

Employer _____

Address _____ County _____

City _____ State _____ Zip (9 digit) _____

Site Contact Person _____

Site Contact Person's Phone _____

Site Contact Person's Email _____ Fax _____

Employment date of health professional _____

If not currently employed by service site, on what date will your employment begin? _____

5. If the answer is yes to any of the following questions, please provide detailed information on a separate sheet of paper.

1. Does the planned service site accept all patients regardless of insurance status or ability to pay? _____
2. Has your license ever been suspended or revoked? _____
3. Are there any professional disciplinary actions pending against you? _____
4. Are there any restrictions on your license? _____
5. Have you ever been convicted of or pled guilty to a felony as so defined under federal or state law? _____
6. Do you have an existing service obligation that will not be completed by the beginning of your Kansas state loan repayment service period? _____
7. Are you in default on any educational loans? _____
8. Have you ever had a judgment lien against your property for a debt to the United States? _____
9. Have you ever defaulted on any Federal payment obligations? (HEAL, Nursing Student Loans, Federal Income tax liability, FHA loans, etc.)? _____

10. Have you ever breached a prior service obligation to the Federal/State/local government or other entity, even if you have subsequently satisfied the obligation? _____
11. Have you ever had any Federal debt written off as uncollectible or had any Federal service or payment obligation waived? _____
12. Do you have any unfulfilled child support obligations? _____
 If yes, please provide the following information: name of child, name, address, and phone number of person to whom payment is mailed, and when this obligation will be complete. _____

6. Eligible Loans

Please list all educational lender names and current loan balances for which you are requesting Kansas SLRP assistance

Lender 1 _____	Balance \$ _____ as of _____
Lender 2 _____	Balance \$ _____ as of _____
Lender 3 _____	Balance \$ _____ as of _____
Lender 4 _____	Balance \$ _____ as of _____

Total Eligible Debt for which you are seeking assistance through the Kansas SLRP \$ _____

I certify that the information provided in this application packet is accurate and complete to the best of my knowledge. I hereby authorize the Kansas Department of Health and Environment to contact the listed employer and relevant licensing authorities to confirm my eligibility for this program.

Signature of Applicant

Date

Printed Name of Applicant

Questions should be directed to Barbara Huske, 785-296-2742 or bhuske@kdheks.gov.

Please submit provider application with site application to:

Barbara Huske
 Kansas Department of Health and Environment
 Bureau of Local and Rural Health
 1000 SW Jackson St., Suite 340
 Topeka, KS 66612-1365