

Name/Title: _____

Agency: _____

Kansas Department of Health & Environment
Bureau of Local & Rural Health

Site Application
Kansas State Loan Repayment Program

This application form is used to determine site eligibility for local participation in the Kansas State Loan Repayment Program. If you need additional space to answer any of the questions, attach as many pages as needed: type your name, title, and agency at the top of each page.

Name of health professional _____

Social Security Number _____ - _____ - _____

Health professional is: Recruitment (hired within last three months) _____ Retention (existing staff member) _____

Site Information

Name and title of person completing application: _____

Agency _____ FEIN _____

Public entity? Yes ___ No ___ If so, Type of Practice _____

Private Not-for-profit? Yes ___ No ___ If so, Type of Practice _____

Address _____ County _____

City _____ State _____ Zip (9 digit) _____

Site Contact Person _____

Site Contact Person's Email _____

Site Contact Person's Phone _____ Fax _____

Location of clinical practice for health professional, if different from above

Address _____

City _____ State _____ Zip (9 digit) _____

Name of medical and/or dental director at practice site _____

If the answer to any of the following questions is no, please use a separate sheet to provide more detail.

Do the health professional and the service site accept Medicare assignment? _____

Do the health professional and the service site accept Medicaid/SCHIP (HealthWave) patients? _____

Are there any limits on patients the health professional or service site accepts? _____

Name/Title: _____

Agency: _____

Applicant Information

Employment date of health professional _____

Days and hours worked by health professional each week _____

Days and hours worked by health professional providing direct primary patient care each week.

Does this health professional provide specialty care/services? _____

List the proposed salary and benefits for the health professional plus malpractice coverage, if provided by the community. _____

Describe the agency's proposed plan to retain the health professional in the service area upon completion of their service obligation. _____

Service Site Information

Boundaries _____

Population Centers included in this service area: _____

List any **indicators of unusually high need** in the service area, such as unemployment, cultural or language differences in the community, difficulty with primary care access for Medicaid/HealthWave or Medicare clients, etc. _____

Provide the total number full-time equivalent providers employed by the service site in the applicant health professional's discipline (medical, dental, mental health) _____

Provide the total number of active patients at the service site _____

Name/Title: _____

Agency: _____

I certify that the information on this form is accurate and complete to the best of my knowledge, and that our agency has successfully completed negotiations for employment with the health professional.

Signature of Site Official

Date

Printed Name of Site Official

Site Official Title

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

Please submit site application with provider 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