Save Print Reset

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF PRIMARY CARE AND RURAL HEALTH
P.O. BOX 570, JEFFERSON CITY, MO 65102-0570

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

ALL INFORMATION IS CONFIDENTIAL AND FOR PROGRAMMATIC PURPOSES ONLY

MUST BE TYPED OR PRINTED

SECTION 1 – APPLICANT'S PERSONAL INFORMATION

APPLICANTS LAST NAME | FIRST NAME | MI. | APPLICANTS SOCIAL SECURITY NUMBER

OTHER NAMES USED | EMAIL ADDRESS

DATE OF BIRTH | GENDER ☐ M ☐ F | HOME TELEPHONE NUMBER | CELL PHONE NUMBER

☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED | AGES OF DEPENDENTS

HOUSEHOLD INCOME FROM MOST RECENT INCOME TAX RETURN (AGI) (INDICATE TAX RETURN YEAR USED)

PRESENT ADDRESS | STREET | CITY | STATE | ZIP

COUNTY | LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH | US CITIZEN ☐ YES ☐ NO

LAST NAME OF SPOUSE | FIRST NAME | MI. | SPOUSE SOCIAL SECURITY NUMBER

NAME OF RELATIVE NOT LIVING WITH YOU | RELATIONSHIP TO YOU

RELATIVE STREET ADDRESS | CITY | STATE | ZIP | RELATIVE HOME TELEPHONE NUMBER

ADDITIONAL INFORMATION FOR REPORTING PURPOSES (OPTIONAL)

RACE

☐ WHITE ☐ AFRICAN-AMERICAN ☐ AMERICAN INDIAN ☐ CHINESE
☐ JAPANESE ☐ ASIAN INDIAN ☐ KOREAN ☐ VIETNAMESE
☐ HAWAIIAN ☐ SAMOAN ☐ FILIPINO ☐ GUAMAN
☐ OTHER PACIFIC ISLANDER ☐ OTHER _____

HISPANIC ORIGIN? ☐ YES ☐ NO

SECTION 2 – APPLICANTS EMPLOYMENT INFORMATION

EMPLOYER | STREET ADDRESS | CITY | STATE | ZIP

COUNTY | WORK TELEPHONE AND EXTENSION | SUPERVISORS NAME | EMAIL

APPLICANT'S TITLE | DATE EMPLOYED | THIS FACILITY IS ☐ PUBLIC ☐ NON-PROFIT ☐ FOR PROFIT

_____ HOURS WORKED PER WEEK 0.00% % DIRECT PATIENT CARE | DO YOU SEE PATIENTS REGARDLESS OF ABILITY TO PAY ☐ YES ☐ NO

SECTION 3 – APPLICANTS SCHOOL/RESIDENCY PROGRAM INFORMATION

LAST SCHOOL ATTENDED | RESIDENCY PROGRAM (IF APPLICABLE) | DATE COMPLETED (MMDD/YYYY)

OF LIST BELOW, INDICATE THE DEGREE EARNED AND THE COMPLETION DATE

☐ DIPLOMA NURSING DEGREE
☐ ASSOCIATE NURSING DEGREE
☐ BACHELOR NURSING DEGREE
☐ MASTER OF NURSING DEGREE
☐ ADVANCED NURSE PRACTITIONER
☐ DOCTORATE NURSE (Ph.D., D.N.P or Ed.D.)
☐ DOCTOR OF ALLOPATHIC MEDICINE
☐ DOCTOR OF OSTEOPATHIC MEDICINE
☐ DEGREE IN DENTAL SCIENCES
☐ RESIDENCY _____ (TYPE)

MEDICAID PROVIDER NUMBER | MEDICARE PROVIDER NUMBER

ARE YOU A BOARD CERTIFIED PHYSICIAN? ☐ YES ☐ NO | BOARD CERTIFICATION NUMBER | MISSOURI LICENSE NUMBER

LIST ANY OTHER STATES WHERE YOU ARE LICENSED TO PRACTICE AND YOUR LICENSE NUMBER

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

MUST BE TYPED OR PRINTED

SECTION 4 – EDUCATIONAL DEBT INFORMATION

DO YOU HAVE AN EXISTING SERVICE OBLIGATION?	IF YES, DATE TO BE COMPLETED	ARE YOU IN DEFAULT OF THIS OBLIGATION?
☐ YES ☐ NO		☐ YES ☐ NO

NAME OF PROGRAM	TELEPHONE NUMBER

HAVE YOU EVER DEFAULTED ON A STATE OR FEDERAL LOAN?

☐ YES ☐ NO

IF YES, LIST NAME OF LOAN, TYPE OF LOAN AND REASON FOR DEFAULT.

LENDING INSTITUTION OR CURRENT HOLDER OF LOAN	ACCOUNT NUMBER	BALANCE	TELEPHONE NUMBER
TOTAL: (Attach additional sheets if necessary)	$ 0.00		

APPLICATIONS WITHOUT APPROPRIATE ATTACHMENTS WILL NOT BE PROCESSED. THE FOLLOWING INFORMATION MUST BE ATTACHED.

HAVE YOU ENCLOSED?

- ☐ LETTER OF SUPPORT/RECOMMENDATION FROM YOUR EMPLOYER OR COPY OF LATEST PERFORMANCE APPRAISAL
- ☐ PROOF OF OUTSTANDING EDUCATIONAL DEBT (STATEMENTS OR PROMISSORY NOTES - MUST SHOW BEGINNING BALANCE, CURRENT BALANCE AND MONTHLY PAYMENT AMOUNT)
- ☐ COPY OF YOUR CURRENT PROFESSIONAL LICENSE
- ☐ COPY OF SLIDING FEE SCALE
- ☐ PAYER MIX PERCENT (MEDICAID, MEDICARE, PRIVATE PAY, ETC.)
- ☐ COPY OF YOUR OFFICIAL JOB DESCRIPTION
- ☐ LIST OF SERVICES PROVIDED BY EMPLOYER
- ☐ EMPLOYMENT ACCEPTANCE LETTER OR COPY OF EMPLOYMENT CONTRACT
- ☐ COPY OF YOUR DOCUMENT OF RECOGNITION (i.e. AMERICAN ASSOCIATION OF NURSE PRACTITIONERS)

The undersigned hereby authorized the full disclosure of any information regarding the nature, amount, terms and status of this loan for the purpose of entering an agreement with the Missouri Department of Health and Senior Services for repayment of said loans.

The undersigned hereby certifies the accuracy of the information in the application and applies to enter into an agreement with the Missouri Department of Health and Senior Services for repayment of a portion of the educational loans listed above.

PLEASE PRINT FULL NAME	
SIGNATURE	DATE