Elevating *The Safety Net*
An L.A. Care Health Plan Initiative to Strengthen the Provider Safety Net in L.A. County

UncommonGood
Education. Health. Environment

Provider Loan Repayment Program

APPLICATION

Note : There is no deadline to apply. However, applications are being accepted for the program's waitlist and will be considered when further funds become available. Moving forward, due to limited funding, the awarding process will be more selective and prioritize certain criteria (geographic areas, types of practices, areas of specialization, provider ethnic and cultural background, amount of debt, hours of direct patient care and demonstrated commitment to practicing in underserved communities), which are underfunded by the program.

APPLICANT INFORMATION	
Full Name	Date of Birth
Address	
Gender	Social Security #
Ethnicity	Birthplace (City and State)
Personal Phone	Personal Email

EDUCATION	
Type of Medical Degree ❑ Doctor of Medicine (MD, Dr.MuD, Dr.Med) ❑ Doctor of Osteopathic Medicine (DO) ❑ Other (please specify):_____	**California Physician License Number**

Name of school(s) from which you received your medical degree(s)		
Name	City/State	Graduation Date
Name	City/State	Graduation Date
Name of institution(s) in which residency and/or fellowship training was completed		
Name	City/State	Completion Date
Name	City/State	Completion Date

Are you actively Board Certified or pursuing board certification in one of the following areas?
(check all that apply)

- ❑ Internal Medicine
- ❑ Family Medicine
- ❑ Obstetrics & Gynecology
- ❑ Pediatrics
- ❑ Primary Care Psychiatry

Are you fluent in a language or languages other than English, including sign language?

- ❑ Yes - please indicate language(s): _____
- ❑ No

Do you speak Spanish

- ❑ Yes
- ❑ No

If you marked yes to the previous question, please mark your level of fluency?

- ❑ Fluent
- ❑ Conversational
- ❑ Medical Spanish only.

EMPLOYMENT INFORMATION

Name		
Corporate/Headquarter Address		Suite/Floor
City	State	Zip Code
Work Phone	Work Email	
Date of Hire	Annual Salary	

Is your employer a contracted provider in L.A. Care Health Plan's (L.A. Care) Medi-Cal network?

- ❑ Yes
- ❑ No

EMPLOYER REPRESENTATIVE – Please state contact who can verify your hire date and hours of direct patient primary care at your practice site(s). **Note*:*** The Program Administrator may contact your employer at any time during the review and award process to verify application information and employment status updates.

Name	Title	
Address (including suite/floor)		
City	State	Zip Code
Work Email	Work Phone (include direct extension)	

PRACTICE SITE INFORMATION

Are you committed to serving in L.A. Care's Medi-Cal Network for at least three (3) years?

- ❑ Yes
- ❑ No

If you will provide direct patient care at more than one (1) practice site, please provide the following information for all individual practice sites below.

IMPORTANT NOTE: Each suite/floor is considered a practice site

Practice Site #1		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	Service Planning Area (SPA)

Practice Site #2		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	Service Planning Area (SPA)

Practice Site #3		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	Service Planning Area (SPA)

Prior to accepting employment from the employer you have listed in the Employment Information section of this application, have you worked for another employer providing primary care to the Los Angeles County Medi-Cal network?

- ❑ Yes
- ❑ No

If yes, please provide the name, address, and dates of employment for each of these employers:

Previous Employer Name	Previous Employer Address
Dates of Employment	

Previous Employer Name	Previous Employer Address
Dates of Employment	

Previous Employer Name	Previous Employer Address
Dates of Employment	

EDUCATIONAL DEBT INFORMATION

IMPORTANT NOTE: For each loan listed, please provide copies of the underlying loan documents and promissory notes. Please print your name at the top of any additional sheets.

Loan 1	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

Loan 2	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

Loan 3	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

Loan 4	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

OTHER LOAN REPAYMENT ASSISTANCE PROGRAM(S): Eligibility and Participation

Are you eligible and participating in other loan repayment assistance programs?

- ❑ Yes – please provide the information for each program in the section below
- ❑ No – there is no other loan repayment program to which I can apply

Loan Repayment Program #1

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by_____(MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is_____(MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

Award Amount: $ _____

Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #2

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by_____(MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is_____(MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

Award Amount: $ _____

Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #3

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ❑ **APPLIED** - I expect to receive notification by_____(MM/DD/YEAR or closest approximation).
- ❑ **INTEND TO APPLY** – The application deadline is_____(MM/DD/YEAR).
- ❑ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

Award Amount: $ _____

Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Attach additional sheets if necessary. Print your name at the top of any additional sheets.

Please describe how you have demonstrated cultural sensitivity to your patient communities, a long-term interest in providing access to quality health care for vulnerable and low-income individuals and families, and leadership potential in the community health field.

Elevating *The Safety Net*
An L.A. Care Health Plan Initiative to Strengthen the Provider Safety Net in L.A. County

UncommonGood
Education Health Environment

REQUIRED DOCUMENTS

- ❑ Completed Application
- ❑ Board Certifications (not required for program)
- ❑ Most recently filed tax return
- ❑ Proof of outstanding educational loan balances (i.e. loan statements)
- ❑ Other loan repayment assistance program award letter(s) or promissory note(s), if applicable

SUBMISSION PROCESS: Submit all materials via mail or e-mail to Program Administrator

MAIL	**EMAIL**
Uncommon Good 211 W. Foothill Blvd. Claremont, CA 91711 Attention: Francesca Twohy-Haines	ftwohy-haines@uncommongood.org Subject Line: Applicant's Name, Provider Loan Repayment Program Attention: Francesca Twohy-Haines

EMPLOYMENT AND CREDENTIALING VERIFICATION

Upon full review of your application and accompanying documents, the Program Administrator will provide an employment verification form to confirm employment and credentialing status.
Please note for continuity of award eligibility and disbursement, the employment verification form does not supersede the standard provider credentialing and facility site review process.

APPLICANT SIGNATURE DISCLAIMER

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in my application being dismissed or my award withdrawn.

Print and Sign Completed Application.
If submitting electronically, please scan and submit as PDF.

Applicant Signature:_____Completion Date: _____

Program Administrator
For support, please contact Francesca Twohy-Haines,
Medicine for the Economically Disadvantaged Program Director, Uncommon Good
Phone: (909) 625-2248 or Email: ftwohy-haines@uncommongood.org