2016 – 2017 State Loan Repayment Program (SLRP)
for Behavioral Health Therapists

Incentive Guidelines

**Loan Repayment:**
Offers up to $30,000.00 for a 2-year service agreement to work in an integrated primary/behavioral health care setting.

**Qualifying disciplines:**
- LCSW  Licensed Clinical Social Worker
- LPC   Licensed Professional Counselor
- MFT   Marriage and Family Therapist
- PNS   Psychiatric Nurse Specialist
- HSP   Health Service Psychologist
  (Clinical & Counseling)

**Qualifying Sites (Primary Care Setting):**
- Federally Qualified Health Centers (FQHCs)
- Community Health Centers (CHCs)
- Migrant Health Centers
- FQHC Look-A-Likes
- CMS Rural Health Clinics
- State Designated Rural Health Centers
- Community Mental Health Facilities
- Critical Access Hospitals
- Health Department Clinics
**Tax Liability**
Not taxable

**Service commitment**
Minimum 2-year service commitment  
Additional 1 year of service for each year of additional support

**Part-Time Service**
SLRP participants are now also eligible for the Part-Time Service option that is available through the National Health Service Corps.  
For information, NHSC.hrsa.gov/loanrepayment/halftimeprogram

**Application Requirement:**
- U.S. citizen (U.S. born or naturalized), U.S. national, or Lawful Permanent Resident  
- Licensed to practice in the state where they will work (where work will occur)  
- Currently work or be applying to or accepted to work at an eligible site that is located in a federally designated Health Professional Shortage Area (HPSA)  
- Unpaid government or commercial loans for school tuition, reasonable education expenses and reasonable living expenses, segregated from all other debts (that is, not consolidated with non-educational loans)

**Termination of State Loan Repayment Contracts:**
- Providers cannot be involved in another incentive program while receiving state loan repayment.  
- Providers will be issued a termination letter to enable them to apply for FLR or another incentive program.

**Disclaimer:**
Guidelines are subject to change at any time, contingent upon funding and per the discretion of the Office of Rural Health.
North Carolina Student Loan Repayment Program (SLRP)

Provider Application

Section A: Applicant Information

Applicant Name

Applicant Address

Street
City State Zip Code

Applicant Phone

Applicant Email

Section B: (For individual provider applicants, please complete on behalf of yourself)

Physician Name

Physician Address

Street
City State Zip Code

Phone

Email

Race/Ethnicity

□ American Indian or Alaskan Native
□ Native Hawaiian or Pacific Islander
□ Asian
□ Black or African American
□ Hispanic or Latino
□ White
□ More Than One Race

□ Decline to Respond

**Discipline**
Find your discipline below. Select from among the options below. You may not select multiple disciplines or specialties for this application.

□ LCSW

□ PNS

□ LPC

□ MFT

□ Health Service Psychologist (Clinical Counseling)

**To be eligible, the identified provider must meet all the following:**
- A U.S. citizen or permanent resident alien holding an I-155 or I-551 card;
- Not fulfilling an obligation under any state or federal loan repayment program where the obligation periods of the state or federal repayment program would overlap or coincide with the NCSLRP period, including any current NCSLRP obligation.
- Not currently working in, or serving, an underserved area, where the current service to the underserved area began prior to July 1, 2010.
- In good standing with the NCSLRP Medical Placement Services.
- Not in the employ of a Federally-operated facility.

**The identified provider meets all the following:** □ Yes □ No

If the provider cannot meet all the above, STOP. The physician is not eligible for ORH/SLRP funding
Current Position: □ Practicing Provider
□ Student/Resident/Fellow

Expected Date of Completion

If you are presently completing a residency, fellowship, or other medical training program, indicate the anticipated date of completion.

Expected Start date of position for which you are requesting ORH/SLRP funding:

Specialty:

Is identified provider currently licensed to practice as a physician in NC?
□ Yes, license number ________________
□ Pending, date applied ________________
□ Currently in residency or a student and have not yet obtained a license

If the identified provider has applied for or received any scholarships, loan forgiveness or other funds for the same or partially overlapping service obligation period that they are applying for in this application, insert the information in the table below.

<table>
<thead>
<tr>
<th>Amount</th>
<th>Date of Award (if applicable)</th>
<th>Dates of Service Obligation</th>
</tr>
</thead>
</table>

National Health Service Corps Scholarship

National Health Service Corps Loan Repayment Award

Loan Repayment Program - Other (Please specify):

If applying for funding provide the physician debt information below (add a separate sheet if necessary):

Creditor Name

Creditor Address

Current Balance
TOTAL: $

Total NCSLRP Grant Funding Amount Requested: $

Do you currently receive National Health Service Corps money?

☐ Yes  ☐ No

Do you have an open application on file with the National Health Service Corps?

☐ Yes  ☐ No

Have you ever defaulted on any Federal payment obligations, e.g., Health Education Assistance Loans, Nursing Student Loans, Federal Income tax liabilities, FHA loans, etc.?

☐ Yes  ☐ No

Have you ever had any Federal debt written off as uncollectable or had any Federal service or payment obligation waived?

☐ Yes  ☐ No

Personal Essay - Attach document

Provide an explanation (maximum 4000 characters, ~750 words) of why you have chosen to practice in this area. In addition, please provide background information on factors that may influence your decision to remain in this area.

Section C: Site Information

Site Name

Site Address

Street

City  State  Zip Code

Contact Name

Contact Phone

Contact Fax

Contact Email

Begin Date (mm/yyyy)
HPSA Score:  
HPSA ID:

Percentage of time spent at this site

How many hours per week will you be working?

How many weeks per year will you be working?

Location of area served by practice site:

- □ Rural
- □ Urban
- □ Other (please specify)

County(ies) served (if applicable):

Town(s) served (if applicable):

Neighborhood(s) served (if applicable):

Population served (if applicable):

Category:

- □ Community Health Center-CHC
- □ Health Department
- □ Non-Profit Organization
- □ Private For-Profit Organizations
- □ Migrant Health Center (MHC)
- □ Federally Qualified Health Center
- □ Public Housing Primary Care
- □ Health Care for Homeless
- □ CMS Rural Health Clinic
- □ Indian Health Service (IHS) or Tribal Health Site
Race/Ethnicity of Patients Served at Site (Select any that apply)

American Indian or Alaskan Native

☐ 1-25%       ☐ 26-50%       ☐ 51-75%       ☐ 76-100%

Native Hawaiian or Other Pacific Islander

☐ 1-25%       ☐ 26-50%       ☐ 51-75%       ☐ 76-100%

Asian

☐ 1-25%       ☐ 26-50%       ☐ 51-75%       ☐ 76-100%

Black or African American

☐ 1-25%       ☐ 26-50%       ☐ 51-75%       ☐ 76-100%

Hispanic or Latino

☐ 1-25%       ☐ 26-50%       ☐ 51-75%       ☐ 76-100%

Section D: Employment Contract or Business Plan

- Be sure to label your documents "Employment Contract" or "Business Plan."
- All Employment Contracts must be signed by the physician and the employer and reflect a two-year service obligation period as described in the instructions.
- If the applicant is an individual provider requesting funds to join a practice, please insert a copy of the fully executed employment contract or partnership.
To complete your application, please provide the following:

1. A signed copy of this application once it is submitted.
2. Copies of the promissory notes on each eligible loan.
3. Copies of the current balance of each eligible loan. You must include a document from your lender(s) clearly indicating the current balance for each loan you entered on page 3. The balance on the documentation must equal the balance you entered for each loan on page 3.
4. Verification from your school(s) regarding program completion and graduation date. Acceptable verification includes either an official copy of your diploma or an official copy of your transcript or a letter from the school.
5. A letter from your employer detailing the community’s commitment to your retention. This should be a brief statement (maximum 500 words) regarding the financial and other support for retention that has been or will be provided by your clinic, individuals, organizations, or local governments (e.g., guaranteed salary, scope of practice, continuing education provisions, provision of vacation time, etc.) The letter should emphasize those things that your clinic has done or intends to do to better assure your retention. If there is an especially high need for this type of provider at the clinic, information related to this or to recruitment issues can also be included in the letter. The letter should also confirm that your salary will not be offset by a Health Professions Loan Assistance Program award, if you are selected.
6. If your employer has a policy for accommodating patients unable to pay full price for services, e.g., a sliding scale system, they must send a copy of that policy to the address below.

Name, title, and signature of individual authorized to the accuracy of the information in this application and to bind the applicant to any contract resulting from this application:

Name (Print)
Signature
Title
☐ I certify that all information I have provided is correct to my knowledge and belief.