

MONTANA RURAL PHYSICIAN INCENTIVE PROGRAM



APPLICATION INSTRUCTIONS

Typically, one application cycle is offered each year for the Montana Rural Physician Incentive Program (MRPIP) with a July application deadline. **The current application cycle is now open with an application deadline of July 24, 2020.** The MRPIP application is a joint application to be submitted by both the physician and the supporting organization (such as a hospital or clinic) located in the community where the physician is practicing or is considering practice. The application form contains sections for both the physician and supporting organization to complete. Supporting organizations must be able to provide ongoing practice information, status, and verifications throughout the physician's program participation.

A separate loan information and verification form is to be completed by both the applicant and lending institution for each individual educational loan account submitted for repayment consideration. Only verifiable medical education debt will qualify for loan repayment. All loan consolidations must include a detailed breakdown of each original loan included in the consolidated loan, clearly identifying the original loan amounts and original disbursement dates. Medical education debt may include undergraduate education debt, but cannot include debt incurred during residency training. A physician who qualifies is not guaranteed the maximum repayment amount.

Program benefits can allow up to a maximum of \$150,000 in loan repayment benefits to be applied toward qualified medical education loans for full-time participating physicians over a one- to five-year period of service in an approved location. Proportionately reduced repayment amounts are available for physicians practicing less than full-time. The maximum eligibility period is five years; awards are not made retroactively. Physicians participating in a state, federal, Indian Health Service (IHS), or other loan repayment program or while completing a state, federal, IHS, or other practice obligation are not eligible for MRPIP participation until completion of the other program or practice obligation.

The supporting organization/institution must prepare and submit documentation explaining the need for assistance with physician recruitment and retention in their community along with their section of the application. This documentation should include at a minimum, a statement addressing the following: 1) the efforts made to recruit physicians over the past five years, 2) the number of physicians lost to retirement or relocation over the past five years, and 3) the reasons why recruitment will continue to be a problem for the community. A copy of the applicant's current curriculum vitae or résumé must be included with the application materials. Applications are to be submitted to the following address:

OFFICE OF THE COMMISSIONER OF HIGHER EDUCATION
MONTANA UNIVERSITY SYSTEM
P O BOX 203201
HELENA, MT 59620-3201

CURRENT APPLICATION CYCLE DEADLINE - JULY 24, 2020



Further information regarding the program and application process may be obtained by contacting Laurie Tobol (406) 449-9153 tobol@montana.edu OR Sheila Newlun (406) 449-9168 snewlun@montana.edu

APPLICANT CHECKLIST AND INSTRUCTIONS

Application Materials to be completed by physician applicants*:

- Pages 1-3 of the MRPIP Application Form
- Page 1 (Part A) of the Loan Information and Verification form for each medical education lender to be considered for loan repayment
 1. Submit the completed page 1 along with the incomplete page 2 to the lending institution(s)
 2. If loan(s) is/are consolidated, then will also need the individual loan amounts and original loan dates
- Copy of a current Résumé or Curriculum Vitae

*Additional documents may be requested if necessary upon initial review of application.

Application Materials to be completed and submitted by Supporting Institution:

- Page 4 of the MRPIP Application Form
- Letter explaining the need for assistance with physician recruitment and retention in their community including at a minimum the following information:
 1. The efforts made to recruit physicians over the past five years
 2. The number of physicians lost to retirement or relocation over the past five years
 3. The reasons why recruitment will continue to be a problem for the community

Application Materials to be completed and submitted by Lending Institution(s):

- Page 2 (Part B) of the Loan Information and Verification form for each medical education lender to be considered for loan repayment.
 1. The lending institution should return both completed pages back to the applicant to submit with application IRS Form W-9

Instructions:

- **DO NOT PRINT YOUR APPLICATION MATERIALS 2-SIDED; SUBMIT SINGLE SIDED MATERIALS ONLY.**
- Print legibly in blue or black ink or type your application and loan information and verification forms.
- Complete all application materials clearly and completely. **Incomplete applications will not be accepted.**
- Include your last, first, and middle name; **full middle name is required.** If your legal name does not include a middle name, please indicate "No Middle Name", **DO NOT LEAVE BLANK.**
- Current mailing address and telephone number must reflect where **you** can be reached throughout the entire application year. If you move or your contact information changes, notify our office **immediately** via email to: ltobol@montana.edu

Completed applications and supporting documentation should be returned by July 24, 2020 to the address listed above. To send your application materials via email, please send them to snewlun@montana.edu using our secure email @ <https://securemail.mus.edu> .

MONTANA RURAL PHYSICIAN INCENTIVE PROGRAM
APPLICATION FORM - SECTION 1
TO BE COMPLETED BY PHYSICIAN

NAME: _____
(Last) (First) (Middle) (Maiden)

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

PLACE OF BIRTH: _____ EMAIL ADDRESS: _____

NPI NUMBER: _____

CHECK APPROPRIATE BOX: US Citizen US National Foreign National of country _____

ETHNICITY: American Indian or Alaska Native Asian Black or African American Latino (Hispanic)
 Native Hawaiian or other Pacific Islander White

HOME ADDRESS: _____ MT CLINIC/BUSINESS NAME & ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

HIGH SCHOOL GRADUATION: _____
(Name and Location of High School) (Graduation Date)

SCHOOL OF MEDICINE OR OSTEOPATHY ATTENDED: _____
(Name and Location of Medical School)

DATES ATTENDED: _____ DEGREE AWARDED: MD DO AWARD DATE: _____

WAS YOUR MEDICAL EDUCATION SUPPORTED THROUGH EITHER WWAMI OR WICHE? Yes No State: _____

RESIDENCY EXPERIENCE:

Dates: _____
Specialty: _____
Institution: _____
Location: _____

RESIDENCY PROGRAM DIRECTOR AND CONTACT INFORMATION:

<u>Name</u>	<u>Address</u>	<u>Phone Number</u>

WORK EXPERIENCE SINCE LEAVING TRAINING: _____

SPECIALTY BOARD CERTIFICATION: Yes No Date: _____

LICENSED TO PRACTICE MEDICINE: Yes No State(s): _____

HAVE YOU EVER BEEN SUBJECT TO DISCIPLINARY ACTION? Yes No

If yes, please explain: _____

HAVE YOU EVER HAD A PROFESSIONAL LICENSE SUSPENDED OR RESTRICTED? Yes No

If yes, please explain: _____

**MONTANA RURAL PHYSICIAN INCENTIVE PROGRAM
APPLICATION FORM – SECTION 1 CONTINUED**

PROFESSIONAL REFERENCES:

<u>Name</u>	<u>Address</u>	<u>Phone Number</u>

OUTSTANDING MEDICAL EDUCATION DEBT:*

<u>Name of Lending Institution</u>	<u>Mailing Address</u>	<u>Phone Number</u>	<u>Account Number</u>	<u>Account Balance</u>

*** Please complete a separate loan verification form for each loan account being submitted for loan repayment consideration.**

IS YOUR SITE IN A FEDERALLY DESIGNATED HEALTH PROFESSIONAL SHORTAGE AREA? Yes No

MEDICAL HPSA SCORE: _____

(Look up your site at: <https://data.hrsa.gov/tools/shortage-area>)

HAVE YOU APPLIED FOR OR RECEIVED LOAN REPAYMENT FROM ANY FEDERAL, STATE, OR OTHER LOAN REPAYMENT PROGRAM(S)? Yes No To Be Determined

If yes, identify program(s) and specific repayment period(s): _____

(Please include a copy of your award letter and graduation/completion letter for verification.)

If no, please indicate why no application is planned or why the location may not qualify: _____

HAVE YOU EVER BREACHED A LOAN REPAYMENT CONTRACT OR FAILED TO FULFILL A LOAN REPAYMENT CONTRACT? IF SO, PLEASE EXPLAIN IN MORE DETAIL: _____

NOTE: Federal repayment assistance may be available under the National Health Services Loan Repayment or Indian Health Service programs. **All MRPIP candidates are expected to apply for such benefits if the practice area/location qualifies.** State, federal, and other loan repayment benefits may not be received concurrently; only qualified medical school loan debts not eligible for repayment under other loan repayment programs are eligible for MRPIP repayment. Physicians participating in a federal, state, Indian Health Service (IHS), or other loan repayment program or while completing a federal, state, IHS, or other practice obligation, are not eligible for MRPIP repayment until completion of the other program. Physicians must notify the MRPIP program when participation in another loan repayment program begins and ends or while serving another practice obligation.

LOCATION OF PRACTICE: _____ TYPE OF PRACTICE: _____

PRACTICE IS EXPECTED TO BE: Full-Time Part-Time FTE: _____

DATE PRACTICE IS EXPECTED TO BEGIN OR BEGAN IF APPLICABLE: _____

REASONS FOR CHOOSING THIS SITE FOR PRACTICE: _____

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

(Signature of Physician)

(Date)

**MONTANA RURAL PHYSICIAN INCENTIVE PROGRAM
APPLICATION FORM - SECTION 2**

TO BE COMPLETED BY SUPPORTING INSTITUTION

(Supporting institution must be able to provide ongoing practice verification and employment status information throughout physician's program participation.)

SUPPORTING ORGANIZATION: _____

ADDRESS: _____
(Physical Address) (City) (State) (Zip)

PHONE: _____ FAX: _____

CONTACT: _____ EMAIL: _____
(Name and Title)

PRIMARY SERVICE AREA POPULATION: _____ PRIMARY SERVICE AREA
PHYSICIAN TO POPULATION RATIO: _____

ON AVERAGE, HOW MANY PATIENTS WOULD/DOES APPLICANT PHYSICIAN SEE WEEKLY? _____

HOSPITAL SIZE (#BEDS): _____ NAME/LOCATION OF LOCAL HOSPITAL: _____

DOES APPLICANT PHYSICIAN HOLD PRIVILEGES AT LOCAL HOSPITAL? Yes No

IF NOT, AT WHAT HOSPITAL DOES APPLICANT HOLD PRIVILEGES? _____
(Name/Location)

LIST ALL PRIMARY CARE PHYSICIANS (MDs and DOs) PRACTICING IN THE PRIMARY SERVICE AREA (Attach additional sheet if necessary):

Name	Type of Practice

CAN THE COMMUNITY DEMONSTRATE A HISTORY OF DIFFICULTY WITH THE RECRUITMENT AND RETENTION OF PRIMARY CARE PHYSICIANS? Yes No

SUPPORTING INSTITUTION/ORGANIZATION: In addition to this page of the MRPIP application, please submit additional documentation to explain in more detail the need for assistance with physician recruitment and retention in your community; include at a minimum, statements addressing 1) the efforts made to recruit physicians over the past five years, 2) the number of physicians lost to retirement or relocation over the past five years, and 3) the reasons why recruitment will continue to be a problem for your community.

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE:

(Signature of Institution Official)

(Title)

(Date)