

**Ohio Department of Health**  
**Application for Loan Repayment**  
**Ohio Dentist Loan Repayment Program (ODLRP)**

**I. Applicant demographics**

Name, last		first	middle	
Social Security number		Home phone (     )	Work phone (     )	
FAX (     )		Pager (     )	Cell phone (     )	
Home E-mail			Work E-mail	
Home address				
City			State	ZIP
Practice address			County of practice	
City			State	ZIP
Are you a: <input type="checkbox"/> US citizen <input type="checkbox"/> Legal alien <input type="checkbox"/> Neither		Date available to practice /   /		Total loan(s) \$
Race (check all that apply) <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> White <input type="checkbox"/> Black or African American <input type="checkbox"/> Pacific Islander/Native Hawaiian			Ethnicity (mark only one) <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Not Hispanic/Latino	
Gender <input type="checkbox"/> Female <input type="checkbox"/> Male				
Background <input type="checkbox"/> From Appalachia <input type="checkbox"/> Not from Appalachia		Number of years	County	State
Dentist speciality: Only primary care dentists are eligible for the state loan repayment program. Please indicate your area of practice. (Select all that apply) <input type="checkbox"/> General Dentistry <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Other dental specialty				
Medicaid provider number		Current employment contract Start date    /    /      End date    /    /		

**II. Education**

Dental school		City	State
Dates of attendance /   /    through    /   /		Date of graduation /   /	
Residency program		City	State
Dates of attendance /   /    through    /   /		Date of graduation /   /	
Any additional training programs		City	State
Dates of attendance /   /    through    /   /		Date of graduation /   /	
Current status (select all that apply) <input type="checkbox"/> Enrolled in final year of dental school or dental residency program <input type="checkbox"/> Practicing in Ohio <input type="checkbox"/> Practicing outside of Ohio			

**Credentials** (required before beginning the program)

List state(s) where you currently hold a license
Note any licensure restrictions

### III. Obligations

Note: All applicants who have an outstanding contractual obligation for health professional service to the federal government (e.g. an active military obligation), a state (e.g. Loan Repayment or Scholarship Program) or other entity are ineligible to participate in the Ohio Dentist Loan Repayment Program (ODLRP), unless that service obligation will be completely satisfied before August 31. Beware that certain bonus clauses in employment contracts may impose a service obligation.

Do you have an existing service obligation?  Yes  No

If **Yes**, give the name of program and practice site address

Program		
Address		
Contact person	Telephone (        )	Completion date /      /
Terms of obligation		
Are you in default of this obligation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you delinquent in the payment of any child support obligation? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Individuals delinquent in child support obligations are not eligible to participate in this program</b>	

### IV. Background and Biographical Statements

On a separate sheet of paper, respond to the following requests to describe:

- A. Your experience living or working in rural or urban areas. Please include the name of your and your spouse's hometown(s).
- B. Two to four professional and personal goals as they relate to your participation in the Ohio Dentist Loan Repayment Program (ODLRP).
- C. Your and your spouse's interest in working and staying in an underserved area.
- D. Student or work experience with **underserved** populations (e.g., community or migrant health centers, free clinics, public health departments, and rural health clinics) during or after the applicant's dental training, including:
  - Location
  - Start and end dates for each student/work experience
  - Number of hours per week spent on the student/work experience
  - Brief description of the experience
  - The knowledge, skills, or abilities gained from the experience
  - Community efforts which lead to improved delivery of dental services to underserved populations
  - Total number of years/months as a clinician providing dental care to underserved populations
  - Published dental care articles
  - Awards for dental care community efforts
- E. Your language skills (including level of proficiency), if any, that the applicant uses or will use to provide services to the patient population of the practice site.
- F. Your awareness of the values, beliefs, and practices as they relate to the health of the population served by the practice site. Include any knowledge, skills, and abilities that will be incorporated into practice to improve the delivery of dental services to the population of the community site.

### V. Professional References (list 2)

1. Name		Title	
Address			
City		State	ZIP
Telephone (        )	E-mail		
2. Name		Title	
Address			
City		State	ZIP
Telephone (        )	E-mail		

### Certification

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willfully false representation is sufficient cause for rejection of this application. I acknowledge I have read the Ohio Dentist Loan Repayment Program Fact Sheet.

Applicant's signature	Date /      /
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# Practice Site Application

## Ohio Dentist Loan Repayment Program (ODLRP)

1. Applicant's name	Telephone	(       )
Practice site name	FAX	(       )
Street address		
City	State	ZIP
E-mail		

2. List hours per week the dentist will practice dental care at each practice site address. List all locations.

Practice site name/address	Hours
Practice site name/address	Hours
Practice site name/address	Hours

3. Does the practice participate in the Ohio Medicaid program?  Yes\*     No
- \*If yes, provide the following.**
- a. Total Medicaid claims paid for the most recent 12 months \_\_\_\_\_
- b. Total number of patient visits for the same time period \_\_\_\_\_
- c. Percentage of the practice comprised of Medicaid patients \_\_\_\_\_%
4. Does the practice accept new Medicaid patients?  Yes\*     No
5. Does the practice provide services regardless of the patients' ability to pay?  Yes     No
6. Does the practice use a sliding fee scale for patients with incomes at or below 200% of the Federal Poverty Guidelines?  Yes\*\*     No
- \*\*If yes, include a copy with the application**
7. Is this practice not-for-profit?  Yes     No

Additional comments

PRINTED name of person completing survey	Phone
Signature of person completing survey	(       )
	Date
	/       /

# Loan Information

## Ohio Dentist Loan Repayment Program (ODLRP)

Directions: Please list only the loans you are requesting to be paid. For each loan listed, attach a copy of the loan agreement and a current statement from the lender showing the balance.

### SECTION I: Applicant information

Name (last, first, MI)		Social Security number
Address		Telephone (        )
City	State	ZIP

Have you consolidated your loans for undergraduate costs with dental school loans or health professions training program loans?

Yes\*    No   **\*If Yes, attach a copy of the loan documents, which reflects the new consolidated loan.**

### SECTION II: Lender information

This program pays for the educational costs for a dental degree, including dental residency programs (AEGD, GPR and Pediatric Dentistry), as listed on page 1 of the application. If loans have been consolidated, a determination will be made of the proportion of the consolidation loan that will be paid for a successful applicant. Only Institutional or Government loans are eligible including Stafford, SLS, HEAL, Perkins, and others.

**Total loan repayment requested for all loans: \$ \_\_\_\_\_**

Award year	Disbursement date	Type of loan/holder	Original loan amount	Current balance	Date of balance	Projected payoff date

Are any parts of the loan(s) listed above being paid by another organization?    Yes\*    No

**\*If Yes, specify the amount being paid for applicable loans and the name of the organization.**

Amount \$	Payer
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### Certification

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any false representation is sufficient cause for rejection of this application.

Signature	Social Security number	Date /        /
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