Montana State Loan Repayment Program (SLRP) Site Eligibility Application

Instructions for completing and submitting a Site eligibility application

Section 1

The "Name of Practice" should be the exact site name and address for the site you are requesting eligibility determination for. If you have multiple sites, each individual site will need its own application. For example: *Primary Clinic* has 3 different locations, each location would have its own application with different names depending on each locations. *Primary Care- Helena, Primary care- Billings* ect.

The "Practice Site Contact" will be the first point of contact for all communications from the Montana Primary care Office. The indicated contact should be the person who can answer questions about your practice and providers, or the person who can route questions to the appropriate individual.

Section 3

Health Professional Shortage Areas (HPSAs) are designated by the Health Resources & Services Administration (HRSA)as having shortages of primary care, dental care, or mental health. Not all practice sites will have a HPSA score. To locate your County HPSA please visit https://data.hrsa.gov/tools/shortage-area/by-address for Auto-HPSAs please visit https://data.hrsa.gov/tools/shortage-area/hpsa-find

Section 6

The date range for your site's patient demographics must be an actual date range (e.g. Jan- March 2022). This date range must be at least 3 months. Please note: Site Applications must reflect current data for example if submitted in mid-2023 the application may not contain data from 2022.

Section 6, Part a

Please indicate the number of individual patients seen at your site for your listed date range. For example, if your site has a total of 50 visits during your listed date range, but those 50 visits are made up of 40 individual patients, your site's number of unduplicated patient encounters would be 40.

Section 7

Your practice site's Executive Director or legal representative must initial all assurances that apply to your site. When initialing assurance please use actual initials, rather than "yes" or "no".

If your practice site's Executive Director or legal representative initials to the affirmative in parts C you must include copies of policies and patient forms that coincide with the assurance.

Omitting these documents will void your sites affirmative response to the assurance.

Program Notes

The Montana State Loan Repayment Program (SLRP) follows the NHSC statute, at 42 U.S.C. § 254g(b)(1)(b), which states that a schedule of discounts must be based on an individual's "ability to pay." The pertinent NHSC regulation defines ability to pay in terms of income, **not assets**. Under 42 C.F.R. § 23.9(c)(1), no charge or nominal charge will be made for health services provided by clinicians to individuals within the HPSA with annual incomes at or below the Income Poverty Guidelines. Annual income is also the sole criterion for determining what discounts are available to those who do not make in excess of 200% of the Income Poverty Guidelines.

Montana State Loan Repayment Program (SLRP) Site Eligibility Application

Submission of a complete Site Eligibility Application to the Montana Primary Care Office indicates your sites interest in obtaining site eligibility for the State Loan Repayment Program.

For questions about this application or to submit the completed application and required supporting documents as attached PDF please email: MontanaPCO@mt.gov

1. **Name of Practice Site:**_____
   Street Address: _____
   City:_____ State:_____ Zip:_____ County:_____
   Phone Number:_____ Fax:_____
   Practice Site Contact:_____ Title:_____
   Phone Number:_____ Fax:_____ Contact Email:_____
   Practice Site Website Address:_____

2. **Name of Parent Organization** (if applicable):_____
   Street Address: _____
   City:_____ State:_____ Zip:_____ County:_____
   Name of Executive Director: _____
   Executive Director Phone Number:_____ Fax:_____
   Executive Director Email:_____

3. **Practice Site's Health Professional Shortage Area** (HPSA) Scores:

Primary Medical Care HPSA	Primary HPSA Score_____
Mental Health Care HPSA	Mental HPSA Score_____
Dental Care HPSA	Dental HPSA Score_____

4. **Type of Organization** (please indicate your organization type in each of the following areas):
   a) Please select one: For Profit Nonprofit
   b) Please select one: Private Public
   c) Please select one:
   Rural Health Clinic (Certified)
   Dental Clinic
   Mental Health Clinic/ Facility
   Federally Qualified Health Center/ Community Health Center (FQHC/CHC)
   Critical Access Hospital (CAH)
   Primary Care/ Family Practice Clinic
   Other, specify: _____

5. **Practice Site Patient Information**

The majority of our providers are eligible for reimbursement from: Medicare Medicaid Both

This practice site provides: Inpatient Services Outpatient Services Both

Date range for following patient demographics (minimum 3 months): _____

a) Total number of unduplicated patient encounters at site for above date range: _____
b) Percentage of sliding fee schedule patients: _____
c) Percentage of Medicaid patients: _____
d) Percentage of Medicare patients: _____
e) Percentage of patients below 200% of the federal poverty level (ifavailable): _____

6. Executive Director or legal representative must initial the following applicable assurances.
Answering to the affirmative for all of these assurances is required for participation in the Montana State Loan Repayment Prorgam.

This practice site does not discriminate in the provision of services to an individual because the individual is unable to pay for services.

This practice site does not discriminate in the provision of services to an individual because payment for those services would be made under Medicare, Medicaid or the State Children's Health Insurance Program.

This practice site does not and will not discriminate against anyone on the basis of age, ancestry, disability, race, color, citizenship, national origin, creed, political or religious affiliation, sex (including pregnancy-related conditions), familial or marital status, sexual orientation, gender identity or expression, marital status, military status, unfavorable discharge from the military, status as a protected veteran, or other groups protected by law
(Please attach a copy of these policies to this application).

This practice site utilizes a schedule of fees or payments for the practice site's services that is consistent with local prevailing rates or charges and is designed to cover the site's reasonable cost of operation.

This practice site has a policy to accept all patients regardless of their ability to pay. The policy includes an implemented schedule of discounts (sliding fee scale) for patients whose income is under 200 percent of federal poverty guidelines. This practice site does not conduct asset testing to determine discounts.
(Please attach a copy of this policy, and all applicable patient forms, to this application.)

This practice site accepts assignment for Medicare beneficiaries.

This practice site has entered into an appropriate agreement with the applicable state agency for Medicaid and State Children's Health Insurance Program beneficiaries.

This practice site provides culturally appropriate ambulatory primary health, dental health, and/or mental health care services and function as part of a system of care, which either offers or assures access to ancillary, inpatient, and specialty referrals.

This practice site assures that the salaries for health professionals participating in Loan Repayment programs are based on prevailing rates in the area, and that Loan Repayment contracts will not be used as a salary offset.

This practice site has a documented record of sound fiscal management.

This practice site is aware that if a clinician from the practice site participates in a Loan Repayment program there will be required employment verifications, and the practice site will respond to requests for information in a timely manner

Signature of Executive Director or other legal representative of practice site (required)

By signing below, I attest that the information, data, and answers contained in this Site Application are true and accurate to the best of my knowledge.

Name:_____ Title_____

Signature:_____ Date:_____

Email address of signer:_____

Phone number of signer:_____

Please submit the completed application via email MontanaPCO@mt.gov