**Montana State Loan Repayment Program (SLRP)**

**Site Application**

The Montana SLRP application requires the clinician’s worksite to be a National Health Service Corps (NHSC) Active site or an approved Montana SLRP site. The site must meet the following criteria:

* Be in a Health Professional Shortage Area (HPSA); and
* Provide primary medical care, dental health, or mental health services; and
* See patients regardless of their ability to pay; and
* Be a public or non-profit site.

Federally Qualified Health Centers (FQHCs), Indian Health Service Facilities, Tribally Operated 638 Health Programs, Urban Indian Health Programs, and most correctional facilities qualify. Certified Rural Health Clinics (RHC), Critical Access Hospitals (CAH), Community Mental Health Centers (CMHC), State or Local Health Departments, Community Outpatient Facilities, Private Practices, School-based Clinics, Mobile Units, and Free Clinics are eligible site types.

The HRSA Health Workforce Connector website can be used to verify if your site is an NHSC Active site. [Health Workforce Connector - Home Page (hrsa.gov)](https://connector.hrsa.gov/connector/)

If your site is not an NHSC Active site, the site administrator may complete the Montana SLRP Site Application. For multiple site locations, a separate application must be submitted for each location. Once a Montana SLRP Site is approved, it is valid for three (3) years.

The Montana SLRP follows the NHSC site requirements. <https://nhsc.hrsa.gov/sites/eligibility-requirements>

**Site Application**

1. **Name of Practice Site**:

List the current practice name and include former/alternate names if applicable. If there are multiple site locations, each individual site must have its own application.

The Site Point of Contact will be the first point of contact for all communications from the Montana Primary Care Office. This person is typically the site administrator, human resources officer, or business manager.

Name:

Street Address:

City: State: Zip: County:

Website: Phone Number:

Parent Organization Name (if applicable):

Site Point of Contact: Title:

Site Contact Email: Phone Number:

**2. Practice Site Services:**

Indicate which services your site provides.

Primary Medical Care Pharmacy

Behavioral Health Care Substance Use Disorder Care

Dental Health Care Obstetrical/Maternal Health Care

**3. HPSA** **Scores:**

Enter the Health Professional Shortage Area (HPSA) scores for your site. You can locate your HPSA scores here: <https://data.hrsa.gov/tools/shortage-area/by-address>.

Primary Medical Care HPSA

Mental Health Care HPSA

Dental Health Care HPSA

**4. Type of Organization**:

Please indicate the type of organization for the practice site.

a. Private ­ Public

b. For Profit Non-Profit

c. Site sub-type:

* Federal Qualified Health Center (FQHC/CHC)
* Certified Rural Health Clinic
* Primary Care/ Family Practice Clinic
* Mental Health Clinic/ Facility
* Dental Health Clinic
* American Indian Health Facility
* Critical Access Hospital (CAH)
* School Based Clinic/Program
* Community Outpatient Facility
* Correctional or Detention Facility
* Private Practice
* Other, specify

**5. Sliding Fee Scale Assurances:**

Complete the sliding fee schedule assurances.

a. Does your site provide discounts via a sliding fee schedule for individuals with annual incomes at or below 100% of the [HHS Poverty Guidelines](https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines)?

* Yes No

b. Are these discounts for services at no charge, or at a nominal charge?

* Yes No

c. Does your site provide a schedule of discounts for individuals with annual incomes between 100% and 200% of the HHS Poverty Guidelines?

* Yes No

d. Is eligibility for your sliding fee scale based only on family size and income?

* Yes No

e. Does your fee policy exclude other factors such as assets, insurance application or coverage, citizenship, or population type to assess whether people are eligible?

* Yes No

f. Do you have a non-discrimination policy to provide services to individuals regardless of their ability to pay; whether their payment would be from Medicare, Medicaid, or the Children’s Health Insurance Plan; or based on the individual’s race, color, sex, national origin, disability, religion, age, sexual orientation, or gender identity?

* Yes No

g. Does your site accept Medicare, Medicaid, and CHIP and make every reasonable effort to secure payment, in accordance with the schedule of fees or discounts, from the patient and/or third party?

* Yes No

h. Does your site have posted signage displayed in the office common area and on your website that states no one will be denied services due to the inability to pay, and there is a discounted/sliding fee schedule available based on family size and income?

* Yes No

**6**. **Patient Demographics:**

Complete the patient demographic information for the time frame covering the previous six (6) months.

a. Percentage of patients provided Outpatient services:

b. Percentage of patients provided Inpatient services:

c. Percentage of patients on a sliding fee schedule:

d. Percentage of Medicaid patients:

e. Percentage of Medicare patients:

f. Percentage of CHIP patients:

g. Percentage of patients identifying as homeless:

h. Percentage of patients identifying as American Indian/Alaskan Native:

i. Percentage of patients identifying as migrant farmworker:

j. Total number of unduplicated patient encounters in the past six months:

**7. Attachments:**

Attach each of the listed documents to this application.

a. Sliding fee scale policy:

b. Sliding fee scale:

c. Application for financial assistance:

d. Non-discrimination policy:

e. Photo or copy of posted signage notifying patients of your sliding scale program:

f. Copy of recruitment and retention plan:

g. SUD sites must include documentation of services along with MOUD attestation:

h. Behavioral Health sites must include documentation of access to ancillary, inpatient, and specialty care not provided on site (referral policy, MOU/MOA, contracts, and agreements):

**8. Signatures:**

The site administrator must sign the SLRP Site Application attestation. A secondary contact should also be listed.

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

Primary Contact: Title:

Email address: Phone Number:

Alternate Site Contact: Title:

Email address: Phone Number:

Primary Contact Signature:

Date:

Completed applications may be emailed to the Montana PCO at MontanaPCO@mt.gov.