



Introduction

2024 North Dakota Health Service Corps Application

Instructions: Below is a list of the questions to be answered in the application. Please review the content before proceeding with the application. This will help in the preparation of your application.

Please include the following as attachments within your application:

- A current resume or curriculum vitae in PDF file format.
- Signed copy of your employment contract with all the addendums, if applicable.
- A copy of your North Dakota provider license.
- Upload a history of your medical licenses held.
- A description of any litigation to which you are party.
- Current loan statement from each of your lenders in **ONE** PDF file format.
- Three letters of recommendation, two of which include;
 - Direct Supervisor
 - Other Organization Official
- A signed statement of endorsement and financial commitment to participate in this program from the health care professional's employer (only applicable to the North Dakota Healthcare Student Loan Repayment Program) ; (Form can be found on the PCO website)

Attachments:

- Upload a signed copy of your employment contract with all addendums (if you have one)
- Upload a current resume or curriculum vitae (CV)
- Upload a current monthly bill or billing statement from each lender you listed on the previous page. The uploaded statement(s) **must clearly display your name and address, the lender's name and remittance address, the outstanding loan balance, and loan payment status as "paid current"**. Do not upload reports from the National Student Loan Data System (NSLDS) or personal credit report.
- Upload a copy of your ND license, if applicable.
- Upload a history of your medical licenses held.
- Upload a description of any litigation to which you are party.
- Upload three letters of recommendation.

- Upload the endorsement and financial commitment form (completed by your Employer).

Demographics

Full Legal Name

First

Middle

Last

BirthDate:

	Month	Day	Year
Please Select:	<input type="text" value="v"/>	<input type="text" value="v"/>	<input type="text" value="v"/>

What is your gender?

- Male
- Female
- Prefer not to answer
- Other, please specify

What is your race?

- American Indian or Alaska Native
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- White
- Prefer not to answer
- Other, please specify

What is your ethnicity?

Contact Informaiton

Enter your address

Physical Address

City

State

Zip

Mailing Address

City

State

Zip

Contact information

Primary Phone Number

Alternate Phone Number

Email address

Professional Information

Citizenship

Veteran Status (this answer is required for federally funded grant data reporting)

Background

Are you from a rural background? (Rural background: a geographical area located in a non-metropolitan county, or an area located in a metropolitan county designated by the Federal Office of Rural Health Policy as rural)

Yes

No

Are you from a disadvantaged background?

Someone who is any/all of these:

Environmentally Disadvantaged - A person's environment inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions school.

Economically Disadvantaged - A person from a family with an annual income below a level based on low-income thresholds, according to family size established by the US Census Bureau, adjusted annually for charges in the Consumer Price Index, and adjusted by the Secretary of the US Department of Health and Human Services, for use in all health professions programs. A family is a group of two or more people. The Secretary updates these income levels in the Federal Register annually.

Educationally Disadvantaged - A person who comes from a social, cultural, or educational environment that has demonstrably and directly inhibited the person from obtaining the knowledge, skills, and abilities necessary to develop and participate in a health professions education or training program.

This person must also be a citizen, national, or a lawful permanent resident of one of these:

- United States
- Commonwealths of Puerto Rico Marianas Islands
- US Virgin Islands
- Guam
- American Samoa
- Trust Territory of the Pacific Islands Republic of Palau

Republic of the Marshall Islands Federated State of Micronesia

- Yes
- No

Professional Information

What is your Professional occupation?

Occupation specialty and/or other credentials

What is your National Provider Identifier ([NPI](#))

What is your exact job title?

What are your primary job duties?

Are you exempt from ND licensure?

- Yes
- No

Have you ever had a Board of Licensure action taken against your Professional license?

- Yes
- No

Has your Professional occupational license ever been revoked?

- Yes
- No

Support and Service Obligation

For which program are you applying:

What is your current work status?

Which clinical practice/student loan reimbursement incentive program(s) have you participated in, if any? Please provide obligation end dates.

Do you currently have or anticipate having another service obligation with any other entity? Please note, you **CANNOT** be enrolled in more than one service obligation simultaneously.

Exceptions apply, please list any employer bonuses, military service, commission corps, etc. below.

Practice Site:

Are you currently employed or job seeking?

Practice Site

Site Name

Employer

Physical Site Address

City

Zip Code

Work Phone

Work Email Address

Actual Start Date

Is this the clinical practice you will be fulfilling your service obligation at?

- Yes
- No

If no, where you will be fulfilling your service obligation at?

Direct Patient Care

Direct Patient Care

“Direct patient care” means the direct delivery of healthcare services to a patient, the occurrence of which is not mediated by others, including clinical supervisees (aka direct care). This may include varied case-specific duties such as the case consultation, case management, treatment team meetings, individual records, and management of an individual’s medications.

ND Federal LRP requires 80% direct patient care.

Administrative

“Administrative Duties,” means those activities that include program management, administration, research, teaching, medical director or clinical director functions, supervisory tasks, including clinical supervision. These are not classified as direct patient care.

What is the average number of clinical (direct patient care) hours you work per week?

What is the average number of administrative hours you work per week?

In a typical week are you routinely scheduled to practice at any other clinical site or with any other employer or in any other specialty (e.g., Emergency Medicine)

If yes, describe the nature of your other practice time

In a typical week, do you spend any time working in an outpatient facility?

If yes, how many hours?

In a typical week, do you spend any time working in an inpatient facility

If yes, how many hours?

Describe the nature of your inpatient facility work.

Payer Information

Does your Employer accept Medicare?

- Yes
- No

Does your Employer accept Medicaid?

- Yes

No

Does your Employer accept CHIP?

Yes

No

Are you practicing in Bismarck/Mandan, Fargo, West Fargo, or Grand Forks?

Yes

No

Choose one of the following:

I will provide at least twenty thousand dollars of dental service to Medicaid clients per year, or

I will provide at least two days per week at a public health or non-profit dental clinic that uses a sliding fee schedule to bill the clinic's patients.

Telehealth

Do you provide telehealth services at your practice site?

If yes, how many hours of telehealth a week do you provide?

Do you provide telehealth services at a location other than your practice site?

If yes, how many hours do you provide?

What is the setting/location in which you provide services?

Site Administrator Information

Enter the contact information for your Human Resources Administrator at your location. If your organization does not have an HR Administrator, enter information for the CEO, Executive Director, or Superintendent.

First Name	<input type="text"/>
Last Name	<input type="text"/>
Email Address	<input type="text"/>
Phone Number	<input type="text"/>

Enter the contact information for your employer's team member who signs contracts for the facility (usually it is the CFO or CEO)

First Name	<input type="text"/>
Last Name	<input type="text"/>
Email Address	<input type="text"/>
Phone Number	<input type="text"/>

Education and Training

Undergraduate

Educational Institution	<input type="text"/>
Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip	<input type="text"/>
Year of Graduation/Completion Date	<input type="text"/>
Degree Received	<input type="text"/>

Graduate

Educational Institution	<input type="text"/>
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Address

City

State

Zip

Year of Graduation/Completion Date

Degree Received

Professional School

Educational Institution

Address

City

State

Zip

Year of Graduation/Completion Date

Degree Received

Medical Residency (Site/Sites of work), if applicable

Educational Institution

Address

City

State

Zip

Year of Graduation/Completion Date

Degree Received

Can you provide clinical services in any other language(s) other than English?

Yes

No

If yes, what language(s)?

Post-secondary education

Do you have any post-secondary education unrelated to your clinical degree?

Degree Name	<input type="text"/>
Study-Major	<input type="text"/>
Year of Graduation/Completion Date	<input type="text"/>
Degree Received	<input type="text"/>

Do you have additional post-secondary education unrelated to your clinical degree?
(Answering Yes and clicking next will repeat the question for additional post-secondary education to be added)

- Yes
- No

Licensure

Are you currently in any litigation or have any actions pending?

Please upload a description of any litigation to which you are a party.

Licensure List

Licensure

State	<input type="text"/>
Year	<input type="text"/>
License Number	<input type="text"/>
Current Status Active/Inactive	<input type="text"/>
Expiration Date	<input type="text"/>

Do you have additional licensures to add?

(Answering Yes and clicking next will repeat the question for additional Licensure's to be added)

Yes

No

Loans

Qualifying education loan debt includes government and commercial loans for actual costs off educational and living expenses related to your undergraduate and graduate education. Qualifying debt must be associated with a degree in the health profession in which you will satisfy your service obligation. Educational loan debt associated with other post--secondary degrees, unrelated to your health professional degree, is ineligible for loan repayment under this program. These loans should NOT be entered below.

Primary Care Loans issued by the federal Health Resources and Service Administration (HRSA) are also NOT eligible for loan repayment under this program

Have you ever been in default on any educational loan(s)

If yes, please explain

Are you working towards Public Service Loan Forgiveness (PSLF)?

How many years until you have met your 120 qualifying payments?

Lenders

Enter the full name(s) of your educational loan lenders/servicing companies. If you have more than one loan with a lender or services, you only need to list that lender or servicer once below. Enter multiple lenders by answering the next question yes and pressing next.

Lender Name

Loan Balance Amount

Enter another lender?

Yes

No

Other Services

Do you provide SUD services? (Individual Holds a Substance Use Disorder License or Certificate)

Do you provide MAT services Select Medication Assisted Treatment (MAT) Services Provided by Individual? If so, which of the following?

- Buprenorphine
- Counseling
- Methadone
- Naltrexone
- None of the Above

Select any key services provided by you as a provider below:

- COVID-19 Treatment or Prevention Services
- Integrated Behavioral Health in Primary Care Services
- Substance Use Treatment Services
- Telehealth Services
- None of the Above

Select if you participated in any HRSA/BHW Program Individual Participated in Prior to Entering NHSC SLRP below.

- Advanced Nursing Education
- Area Health Education Centers
- Behavioral Health Workforce Education and Training
- Centers of Excellence
- Childrens Hospital Graduate Medical Education
- Geriatric Workforce Enhancement Program
- Graduate Psychology Education
- Health Careers Opportunity Program
- Preventative Medicine Residencies
- Primary Care Training and Enhancement
- Public Health Training Centers
- Scholarships for Disadvantaged Students
- Teaching Health Centers Graduate Medical Education
- Veterans Bachelor of Science in Nursing
- None of the Above

Employer Match

Employer Match (Only required for the ND Healthcare Professional Loan Repayment Program):

It is the responsibility of the of **Employer** to provide the required match dollars as outlined in North Dakota Century Code 43-12.3. If you are selected for a loan award, a contract will be sent to the Site Administrator listed in this application. If your employer is not willing to match, you are **NOT** eligible for this program. Please check out the North Dakota Primary Care Office website for additional guidance on the community match.

Award amount may not exceed outstanding student loan debt

Discipline	State Match	Employer Match	Total Award
Physician (MD, DO)	\$100,000	\$50,000	\$150,000
Advanced Practice (NP, PA, CRNA, CNM)	\$20,000	\$2,000	\$22,000
Clinical Psychologist	\$60,000	\$15,000	\$75,000
Registered Nurse	\$20,000	\$2,000	\$22,000
Behavioral Health (LBSW, LMSW, LCSW, LPC, LAC, RN, Behavioral Analyst)	\$20,000	\$2,000	\$22,000

Please upload the endorsement and financial commitment form completed by your employer.

*Your Employer must complete the endorsement and financial commitment form found on the Primary Care Office webpage.

This document must be uploaded as an attachment to your application.

Personal Statement

Enter a personal statement describing your interest in and commitment to serving the underserved people of the community where you practice. Your essay limit is 5000

characters including spaces. Please clearly address each off the following:

What led you to pursue a career in a rural or underserved area in North Dakota?

Describe your life experiences, including experiences living or working in a rural//underserved area.

How have you immersed yourself into the community you serve? Describe how you see your future personal and professional ties to the community.

How have health disparities influenced your career path? Feel free to include personal or professional experiences.

Where do you see yourself professionally after you complete your service obligation?



Attachments

Upload a current resume or curriculum vitae in PDF file format.

Upload a signed copy of your employment contract with all addendums, if applicable.

A copy of your North Dakota provider license.

Upload a history of all medical licenses held.

Current loan statement from each of your lenders in ONE PDF file format.

References

Upload three letters of recommendation, two of which include: Direct Supervisor and Other Organization Official.

Application Review

Your application will only be reviewed if it is complete and received by March 31, 2024, deadline by 11:59 PM.

A complete application includes all required supporting documentation. Applications missing any of the requested documentation or site application will not be reviewed. By signing on the next page, you attest that all statements contained in the application are true and accurate to the best of your knowledge. Any materially false statement may disqualify you from consideration in the current and any future award cycle. Should a materially false statement be discovered after an award is made, your contract may be in default, which could result in significant financial penalties.

By submitting this application, you are authorizing representatives of the ND Primary Care Office at the ND Health and Human Services to contact your educational institutions, employers, supervisors, professional licensing boards, lenders, and those who wrote letters of support on your behalf to verify the information contained in your application.

By submitting this application, you also authorize the Primary Care Office to conduct a general background check. If you are selected for an award from this program, you will enter a minimum 24-month contract with the state of North Dakota that will require continuous practice at an eligible practice site. Your contract will require that you maintain all attributes of your practice that makes you eligible to receive an award throughout your term of service. Failure to do so may cause a contract default, which could result in significant financial penalties.

Application Signature

Use your mouse or track pad to create a signature in the cell below. Please use care to assure that it is legible and recognizable as your signature.

- Hitting the next button on the bottom right-hand corner of the screen will submit your application and you will not be able to return to make changes. Please make sure all aspects of your application are complete before hitting next.



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