L.A. Care | Elevating The Safety Net
An L.A. Care Health Plan Initiative to Strengthen the Provider Safety Net in L.A. County

UncommonGood
Education Health Environment

Physician Loan Repayment Program

APPLICATION

Note: There is *no deadline* to apply. However, the number of awards is dependent on the number of eligible applications and availability of funding.

APPLICANT INFORMATION	
Full Name	Date of Birth
Gender	Social Security #
Ethnicity	Country of Origin
Personal Phone	Work Phone
Personal Email	Work Email

EDUCATION

Type of Medical Degree

- ☐ Doctor of Medicine (MD, Dr.MuD, Dr.Med)
- ☐ Doctor of Osteopathic Medicine (DO)
- ☐ Other(please specify):_____

California Physician License Number

Name of school(s) from which you received your medical degree(s)

Name	City/State	Graduation Date
Name	City/State	Graduation Date
Name	City/State	Graduation Date

Are you actively Board Certified in one of the following areas (check all that apply)?

- ☐ Internal Medicine
- ☐ Family Medicine
- ☐ Obstetrics & Gynecology
- ☐ Pediatrics

Are you fluent in a language or languages other than English?

- ☐ Yes - please indicate language(s): _____
- ☐ No

Do you speak medical Spanish?

- ☐ Yes
- ☐ No

EMPLOYMENT INFORMATION

Name		
Corporate/Headquarter Address		Suite/Floor
City	State	Zip Code
Phone	Fax	Email
Date of Hire	Annual Salary	

Is your employer a contracted provider in L.A. Care Health Plan's (L.A. Care) Medi-Cal network?

- ☐ Yes
- ☐ No

EMPLOYER REPRESENTATIVE who can verify your hire date and the number of hours of direct patient primary care that you provide weekly at your practice site(s). **Note:** The Program Administrator may contact your employer at any time during the review and award process to verify application information and employment status updates.

Name	Title	
Address (including suite/floor)		
City	State	Zip Code
Work Email	Work Phone (include direct extension)	

PRACTICE SITE INFORMATION

Are you committed to serving in L.A. Care's Medi-Cal Network for at least three (3) years?

- ☐ Yes
- ☐ No

Will you be providing direct patient care at more than one (1) practice site?

- ☐ No – please complete details in section *Practice Site #1 only*
- ☐ Yes – please provide the following information for individual practice sites below

IMPORTANT NOTE: Each suite/floor is considered a practice site

Practice Site #1

Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #2		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #3		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

Practice Site #4		
Employer Name	Number of **hours of direct patient primary care** that you provide each week at this site	
Site Address		Suite/Floor
City	State	Zip Code
Site Phone Number	Site NPI Number	

EDUCATIONAL DEBT INFORMATION

IMPORTANT NOTE: For each loan listed, provide copies of the underlying loan documents and promissory notes. Print your name at the top of any additional sheets

Loan 1	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

Loan 2	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

Loan 3	Lender Name	Account Number

Phone Number	Original Loan Amount	Current Loan Amount

Loan 4	Lender Name	Account Number
Phone Number	Original Loan Amount	Current Loan Amount

OTHER LOAN REPAYMENT ASSISTANCE PROGRAM(S): Eligibility and Participation

Are you eligible and participating in other loan repayment assistance programs?

- ☐ No – there is no other loan repayment program to which I can apply
- ☐ Yes – please provide the information for each program in the section below

Loan Repayment Program #1

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ☐ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).
- ☐ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).
- ☐ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

  Award Amount: $ _____

  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #2

Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

- ☐ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).
- ☐ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).
- ☐ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

  Award Amount: $ _____

  Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Loan Repayment Program #3	
Name of Program	Type of Program (school-based, employer, state, other)
Name of Program Contact	Title
Phone Number	Email

☐ **APPLIED** - I expect to receive notification by _____ (MM/DD/YEAR or closest approximation).

☐ **INTEND TO APPLY** – The application deadline is _____ (MM/DD/YEAR).

☐ **APPLIED and DEEMED ELIGIBLE**. *Please attach a copy of award letter or promissory note from this program*

Award Amount: $ _____

Frequency of Award Distribution (One-time, Monthly, Annually, etc.): _____

Attach additional sheets if necessary. Print your name at the top of any additional sheets.

APPLICANT PERSONAL STATEMENT *(You may use additional pages if necessary)*

Please describe how you have demonstrated cultural sensitivity to your patient communities, a long-term interest in providing access to quality health care for vulnerable and low-income individuals and families, and leadership potential in the community health field.

Elevating *The Safety Net*
An L.A. Care Health Plan Initiative to Strengthen the Provider Safety Net in L.A. County

UncommonGood
Education Health Environment

REQUIRED DOCUMENTS

- ☐ Completed Application
- ☐ Board Certifications
- ☐ Most recently filed tax return
- ☐ Proof of outstanding educational loan balances (i.e. loan statements)
- ☐ Other loan repayment assistance program award letter(s) or promissory note(s), if applicable

SUBMISSION PROCESS: Submit all materials via mail or e-mail to Program Administrator

MAIL	**EMAIL**
Uncommon Good 211 W. Foothill Blvd. Claremont, CA 91711 Attention: Nancy Mintie	nmintie@uncommongood.org Subject Line: Applicant's Name, Physician Loan Repayment Program Attention: Nancy Mintie

APPLICANT SIGNATURE DISCLAIMER

I certify that my answers are true and complete to the best of my knowledge. I understand that false or misleading information in my application may result in my application being dismissed.

Print and Sign Completed Application.
If submitting electronically, please scan and submit as PDF.

Applicant Signature : _____ Completion Date:_____

Program Administrator

For support, please contact Nancy Mintie, Executive Director, Uncommon Good
Phone: (909) 625-2248 or Email: nmintie@uncommongood.org

PL0461 0119

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997