Georgia Board of Health Care Workforce

James Barber, MD
BOARD CHAIRMAN

Chet Bhasin, FACHE
EXECUTIVE DIRECTOR

2 MLK JR DR, SE, 11th Floor, East Tower • Atlanta, GA 30334
Main (404) 232-7972 • *healthcareworkforce.georgia.gov* • *gbhcw@dch.ga.gov*

Dear Applicant:

Enclosed are application materials for the **Dentists for Rural Areas Assistance Loan Repayment Program (DRAA).** The attached **Applicant Information Bulletin** gives a description of the program.

The purpose of this program is to grant service cancelable loans, of up to $25,000, to dentists to repay outstanding Dental education debt in return for Dental practice in underserved rural areas in Georgia. Contracts are awarded for one year and are renewable for a maximum of four years.

Please complete the attached DRAA application and return it with attachments by **November 1st**. **All** application materials, including completed Lender Disclosure Forms, must be received by this date. Applications will be presented to the Georgia Board of Health Care Workforce at the next meeting after the application deadline. All applicants will be notified of award status within 10 days of the meeting.

Please contact our office at **(404) 463-1057** or **lauren.brenneman1@dch.ga.gov** if you have questions.

Sincerely,

Chet Bhasin
Chet Bhasin, FACHE
Executive Director

GEORGIA BOARD OF HEALTH CARE WORKFORCE

Dentists for Rural Area Assistance

Loan Repayment Program

PURPOSE OF THE PROGRAM

The purpose of the Dentists for Rural Areas Assistance Loan Repayment Program (DRAA) is to increase access to high quality dental care in underserved, rural communities in Georgia.

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

The DRAA repays dental education student loan debt for dentists who agree to practice dentistry full time in a rural community in Georgia. The program provides up to $25,000 a year in student loan repayment in return for a 12-month commitment to practice in a rural community. Recipients may receive a maximum of four loans and a maximum total student loan repayment of $100,000.

The Dentists for Rural Areas Assistance Contract requires a commitment to practice dentistry for a minimum of 40 clinical hours per week in a Georgia County with a population of **50,000** or less people according to the 2010 Census Count of the United States Bureau of the Census. The practice time requirement can be split between two or more counties, provided that none of the practice location counties exceeds the **50,000** population limit.

The dentist may own the practice or the dentist may be employed by a hospital, group dental practice, community health center, or other health care organization. There is no requirement that the practice be a not for profit organization. However, the dentist must participate in the Medicaid program, must agree to accept new patients insured by Medicaid, and actively treat Medicaid patients.

Funding is based upon the amount of funds appropriated to the Georgia Board of Health Care Workforce by the Georgia General Assembly. Maximum funding will be up to $25,000 each. Funds are disbursed in a lump sum directly to the recipient's lenders.

All recipients are required to sign a contract with the Georgia Board of Health Care Workforce agreeing to the terms and conditions upon which awards are granted. This contract establishes the amount of the award, the location of service repayment, the contract date (also the beginning and end date of service), as well as the terms and conditions of program participation, obligated service, and the conditions of default and cash repayment.

ELIGIBLE STUDENT LOANS

Student loans incurred for tuition, fees, and other expenses associated with completion of your dental degree are eligible for payment under the Dentists for Rural Areas Assistance Program.

Student loan debt incurred to complete other academic degrees is not eligible for payment under the Dentists for Rural Areas Assistance Program.

APPLICATION REQUIREMENTS

Eligible Applicants must:

- Be a citizen, legal resident, or foreign national of the United States;
- Have satisfied all requirements for unrestricted dental licensure by the Georgia Board of Dentistry;
- Be a graduate of an accredited graduate dental education program located in the United States which has received accreditation or provisional accreditation by the American Dental Association's Commission on Dental Accreditation;
- Hold or be in the process of receiving a Medicaid Provider Number in Georgia and actively treat Medicaid patients;
- Be in good standing with regard to meeting the contractual requirements of all existing student loans. Applications will not be considered if the applicant has had a previous loan default even if the lender now considers the defaulted loan in good standing;
- Submit an application and all required materials to participate in the DRAA no later than November 1st. (Submitting an application does not guarantee selection);
- Disclose all outstanding **Dental** education loan debt; If loans have been consolidated, submit documentation showing dates of original loan disbursement;
- Submit executed copy of employment contract. If self employed in private practice, applicant must submit a copy of any other agreements/contracts;
- Contractually agree to practice full-time (minimum of 40 clinical hours per week as defined in GBHCW Rules and Regulations Chapter 195-14-.01(18));
- Complete and notarize Affidavit of Lawful Presence in the United States (form provided) and submit a copy of an approved secure and verifiable document (from provided document list); and
- Have completely satisfied any other obligation for health professional service owed under any agreement with the Federal Government, State Government, or other entity prior to beginning service under this program

APPLICATION PROCESS

Fully completed applications must be received no later than **November 1st** for consideration during the fiscal year. Applications will not be considered complete unless **ALL** application materials, including completed Lender Disclosure Forms, are received by this date.

Application forms are available from the Georgia Board of Health Care Workforce office at 2 MLK JR. DR SE, 11th Floor, East Tower, Atlanta, Georgia 30334, telephone (404) 232-7972. A downloadable version of the application form is available at www.healthcareworkforce.georgia.gov.

Further information is available by contacting the Board office. The Board may request that the candidate make a personal appearance before the Board, although this is not typically the case.

A Notice of Award letter and Acceptance of Award form will be mailed to those applicants approved by the Board. Upon receipt of the Acceptance of the Award form, the Board will issue the DRAA contract. Payment of the Award is made once the contract is fully executed.

Recipients may reapply for additional one-year terms for a maximum of four years or up to $100,000. Each recipient is required to complete and submit an annual status report to the Board.

CONTRACT DEFAULT

The penalty for defaulting on the DRAA contract is double the principal award amount received. Contracts can be defaulted for:

- Failure to begin or complete the full twelve-month service commitment in the location named in the contract;
- Failure to meet the 40 clinical hours per week full-time practice commitment (as defined in Chapter 195-14 of the GBHCW Rules and Regulations); or
- Failure to provide Board staff with access to records and other information necessary to document compliance with contract terms.

The cost of attorney fees and other expenses associated with collection are assessed in addition to the default penalty.

FURTHER INFORMATION AND ASSISTANCE

Please contact the Board if you have questions or need additional information.

Georgia Board of Health Care Workforce
2 MLK JR DR, SE
11th Floor, East Tower
Atlanta, Georgia 30334
404-463-1057- Office
404-656-2596- Fax
lauren.brenneman1@dch.ga.gov
www.healthcareworkforce.georgia.gov

Georgia Board of Health Care Workforce

Dentists for Rural Areas Assistance Program Application

Cover Sheet

Please place this cover sheet on top of your application when it is returned. Please initial by each item signifying that it is enclosed. All materials must be returned under this cover sheet in one packet and postmarked by November 1st. Incomplete applications will not be considered.

Applicant's Name _____

Materials Enclosed With This Packet:

_____DRAA Application (pages 6-10), with proper notary signature

_____Authorization and Release Form (page 12), with proper notary signature

_____O.C.G.A. 50-36-1(e)(2) Affidavit (page 13), with proper notary signature

_____Copy of at least one secure and verifiable document (list provided on pages 14-15)

_____Copy of ALL contracts between applicant and employer (s)

Materials Mailed Directly Lender (Do Not Mail Original Lender Disclosure to GBHCW):

_____Lender Disclosure form(s) (page 11) sent to Lender(s) Date sent to Lenders:_____

By signing below, I am verifying that all documents listed above are enclosed and complete. I understand that it is my responsibility to ensure my lenders return the disclosure forms directly to the GBHCW in the proper time frame. I understand that any disclosures not postmarked by **November 1st** may not be considered.

Applicant Signature_____Date_____

Print Applicant Name_____

Dentists for Rural Areas Assistance Program
c\o Georgia Board of Health Care
Workforce 2 MLK JR DR, SE
11th Floor, East Tower
Atlanta, Georgia 30334

Georgia Board of Health Care Workforce

Dentists for Rural Areas Assistance

Loan Program Application

Please type or print CLEARLY in black or blue ink.

I. Personal Data

Full Legal Name:_____

Address: _____

Must provide street address. No P.O. Boxes

_____

City:_____County:_____

State:_____Zip Code:_____ Date of Birth: _____

Primary Phone:_____Secondary Phone:_____

SSN:_____Email:_____

II. Dental Education

Dental School:_____Graduation Date:_____

City:_____State:_____Degree: ☐ DDS ☐ DMD

Residency Hospital (if Applicable) :_____

Graduation Date:_____

Board Certified: ☐ Yes ☐ No Board Eligible: ☐ Yes ☐ No

Georgia Dental License Number: _____

Medicaid Provider Number(s): _____

IV. Practice Information

Applicant agrees to practice dentistry, full time, for one year at:

Practice Site Name:_____

Address:_____

City:_____County:_____Zip Code:_____

Website:_____

Type of Practice: ☐ Solo [no income guarantee] ☐ Solo [contracted income guarantee]

☐ Group ☐ Other (Please Specify)_____

Number of clinical hours per week at this location: _____

Beginning date of practice:_____Total Annual Compensation:_____

Are you receiving loan repayment through this employer? ☐ Yes ☐ No

If yes, how much and what are the terms? _____

_____

Additional Practice Site Information (if applicable):

Practice Site Name:_____

Address:_____

City:_____County:_____Zip Code:_____

Website:_____

Type of Practice: ☐ Solo [no income guarantee] ☐ Solo [contracted income guarantee]

☐ Group ☐ Other (Please Specify) _____

Number of clinical hours per week at this location: _____

Beginning date of practice:_____Total Annual Compensation:_____

Are you receiving loan repayment through this employer? ☐ Yes ☐ No

If yes, how much and what are the terms? _____

_____

***Include a copy of all contracts between yourself and your practice/employer(s)**
If you are self employed, please provide other contracts indicating ownership

V. Dental Education Debt

Estimate of total outstanding **Dental** education debt from all loan holders: $_____

Request a submission of the attached *Lender Disclosure Form* from each loan holder. Attach a current statement for each loan listed. Loan statements must contain applicant's name, account number, the principal, and pay off balance. *If loans have been consolidated, submit documentation showing dates of original loan disbursement;

1. Loan Holder:_____

Loan Holder Address: _____

City:_____ State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

2. Loan Holder:_____

Loan Holder Address: _____

City:_____ State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

3. Loan Holder:_____

Loan Holder Address: _____

City:_____ State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

4. Loan Holder:_____

Loan Holder Address: _____

City:_____ State:_____Zip Code: _____

Account Number:_____ Loan Balance: $_____

VI. Questions

Please answer the following questions in 250 words or fewer.

Why did you choose to pursue a career in health care?

What has attracted you to live and practice in a rural area?

What excites you most about the future of rural dentistry?

What advice would you offer to a practitioner considering rural medicine?

VII. Certification

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I hereby consent fully to verification of any and all information included in this application. I understand that any willfully false representationof information is sufficient cause for rejection of this application. I have fully disclosed all outstanding loan debt and am not currently in default of any service or loan obligation.

_____ _____

Applicant's Signature (Full Legal Name) **Date**

Official Notary:

I HEREBY CERTIFY that on this day, personally appeared in front of me, an officer duly authorized to administer oath and take acknowledgements,_____ (applicant's name), to me known to be the person described herein and who executed the forgoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____, County of_____and State of_____, this_____day of_____, 20_____.

_____

Notary Public (Full Legal Signature)

Affix Seal My Commission expires: _____

Dentists for Rural Areas Assistance Program

Outstanding Dental Education Loan Debt Information

---------LENDER DISCLOSURE--------

Applicant: This form must be sent to each lending institution or agency for which you are seeking loan repayment. **Please complete the red areas prior to sending to the lender.** The lending institution must forward the completed form to our office **no later than November 1st**.

Lender: If the named individual's application is approved, the information requested below will be used to arrange third party pre-payment of a portion or all of the applicant's debt.

Applicant's Name as it Appears on Loan: _____

Original Lending Institution, Federal or State Program, Please Provide:

_____

Full Name of Institution or Program | Contact Person | Telephone Number

_____

Street Address | City | State | Zip

_____ $_____ _____

Loan ID Number | Original Loan Amount | Date of Original Loan

_____ $_____ _____

Grace Period/Forbearance Dates | Current Balance | Date of Balance

_____% _____

Interest Rate | Simple or Compound

If interest rate is variable, explain terms: _____

Purpose of loan as indicated on <u>original</u> loan application: _____

Certification by Applicant Borrower:

I hereby authorize the government or financial Institution named above to release this information to the Georgia Board of Health Care Workforce for the purpose of repayment of outstanding Dental education debt through the Dentists for Rural Areas As-sistance Program.

I also certify the accuracy of the enclosed information and apply to enter into an agreement with the GEORGIA BOARD OF HEALTH CARE WORKFORCE - DRAA for all or the appropriate portion of the education loan listed above, incurred solely for the cost of Dental education, including reasonable living expense at a school of dentistry.

Full Legal Signature:_____ **Date**: _____

_____

Certification by Authorized Agency of Lending Institution:

The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state or government educational loan, made for the purpose of meeting the borrower's costs of attaining the degree of Doctor of Dental Surgery (D.D.S.) or Doctor of Dental Medicine (D.M.D.).

_____ _____

Print/Type Name of Authorized Agent | Title

Official Signature: _____

Lender Organization's Federal Employer Identification Number:_____

Return to: Georgia Board of Health Care Workforce c/o Lauren Brenneman, 2 MLK JR DR, SE, 11th Floor, East Tower, Atlanta, GA 30334

GEORGIA BOARD OF HEALTH CARE WORKFORCE

AUTHORIZATION and RELEASE FORM

for the Dentists for Rural Areas Assistance Program

FULL LEGAL NAME OF APPLICANT: _____

TO WHOM IT MAY CONCERN:

I,_____, have filed an application with the Georgia Board of Health Care Workforce
Applicant's Full Legal Name

Dentists for Rural Areas Assistance grant to repay the cost of my tuition and other expenses while obtaining my Dental education and training. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons who have entered into a contract with an eligible practice entity, submitted all required application forms and documentation and disclosed all Dental education debts and obligations, are eligible for loan repayment. To this end, and for the entire contract period, I hereby authorize and request any college or school official, lending institution or organization and any other person or official of any firm, association or corporation, to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may by submitted to them by the Georgia Board of Health Care Workforce or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by Georgia Board of Health Care Workforce, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the Georgia Board of Health Care Workforce, who shall comply in good faith with this authorization and request from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said Georgia Board of Health Care Workforce.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in the Official Code of Georgia Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this_____day of_____, 20_____.

_____
Applicant's Full Legal Signature

STATE OF _____ **COUNTY OF** _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments,_____,
Applicant's Full Legal Name
to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at City of_____, County of _____

and State of_____, this_____day of_____, 20_____.

_____
(Place Seal Imprint Here) **Legal Signature, Notary Public**

Revised: October 2015

My Commission Expires: _____

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for the **DRAA Loan Repayment Program**, as referenced in O.C.G.A. § 50-36-1, from the **Georgia Board of Health Care Workforce**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

1) ☐ I am a United States citizen.

2) ☐ I am a legal permanent resident of the United States.

3) ☐ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is:_____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older and has provided at least one secure and verifiable document, as required by O.C.G.A. 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as: _____

_____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in_____(city),_____(state).

_____

Signature of Applicant

_____

Printed Name of Applicant

SUBSCRIBED AND SWORN

BEFORE ME ON THIS THE

_____ DAY OF_____, 20_____

_____

NOTARY PUBLIC

My Commission Expires:

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2

Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 ("IIREA") provides that "[no later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law's website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General." O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G.A.

§ 50-36-2, contains documents that are verifiable for identification purposes, and documents on this list may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A driver's license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Islands, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/index.htm [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]

- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]

In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit.