Georgia Board of Health Care Workforce

William Kemp
BOARD CHAIRMAN

Chet Bhasin, FACHE
EXECUTIVE DIRECTOR

2 Martin Luther King Jr. Drive, SE, East Tower, 11th Floor • Atlanta, GA 30334
Main (404)232-7972 • healthcareworkforce.georgia.gov • gbhcw@dch.ga.gov

Dear Applicant,

Enclosed are the application materials for the Georgia Board of Health Care Workforce's **Dentists for Rural Areas Assistance (DRAA)**. The attached Applicant Information Bulletin provides an overview of the program.

This program offers service-cancelable loans of up to $25,000 to assist dentists and fourth-year dental students in repaying outstanding educational debt in return for medical practice in underserved rural areas of Georgia. Contracts are awarded for one year and may be renewed for up to four years.

Please complete the enclosed DRAA Application and submit it, along with all required attachments, by **November 3rd**. All application materials, including completed Lender Disclosure Forms, must be received by this deadline. Applications will be reviewed at the next Georgia Board of Health Care Workforce meeting following the deadline. All applicants will be notified of their award status within 10 days of the meeting.

If you have any questions, please contact our office at (404) 463-1057.

Sincerely,

Chet Bhasin

Chet Bhasin, FACHE

Executive Director

GEORGIA BOARD OF HEALTH CARE WORKFORCE
DRAA PROGRAM

PURPOSE OF THE PROGRAM

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

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

The DRAA assists with the repayment of student loan debt for dentists who commit to practicing full-time in a rural Georgia community. The program provides up to $25,000 per year in student loan repayment in exchange for a 12-month service commitment. Recipients may receive up to four annual awards, with a maximum total repayment of $100,000.

To qualify, recipients must commit to practicing as a physician for a minimum of 40 clinical hours per week in a Georgia county with a population of 50,000 or fewer residents, as determined by the 2010 United States Census. This requirement may be fulfilled across multiple counties, provided that each county meets the population threshold.

The dentist may own the practice, or eligible employers include hospitals, group practices, community health centers, or other healthcare organizations. While the employer is not required to be a nonprofit entity, the practice must participate in the Medicaid program, accept new Medicaid patients, and actively treat Medicaid-insured individuals.

Program funding is contingent upon appropriations made to the Georgia Board of Health Care Workforce by the Georgia General Assembly.

All recipients must sign a contract with the Georgia Board of Health Care Workforce outlining the terms and conditions of the award. The contract specifies the loan amount, the service location, the contract period (start and end dates of the service commitment), and the terms of participation. It also defines the recipient's obligations, including service expectations, conditions for default, and repayment requirements.

ELIGIBLE STUDENT LOANS

Student loans incurred for tuition, fees, and other expenses directly related to the completion of your medical degree are eligible for repayment under the Dentists for Rural Areas Assistance Program.

Student loan debt incurred for other academic degrees is not eligible for repayment.

APPLICATION REQUIREMENTS

Eligible applicants must:

- Be a U.S. citizen, legal resident, or foreign national of the United States;
- Have fulfilled all requirements for unrestricted medical 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;
- If 4th year dental student submit two letters of recommendation with the application: (1) from a Professor and (2) from a Dean (or Vice Dean) attesting that this applicant is in good academic standing and anticipating graduating by June if a 4th-year dental student.
- Hold or be in the process of receiving a Medicaid Provider Number in Georgia and actively treat Medicaid patients;
- Be in good standing with all existing student loan obligations and not have any current contractual service obligations with the Federal Government, State Government, or other entity prior to beginning service under this program;
- Disclose all outstanding dental education loan debt. Applications will not be considered if the applicant has a history of loan default, even if the defaulted loan is now in good standing. *If loans have been consolidated, include documentation showing the original disbursement dates;
- Submit a signed copy of all current employment contracts;
- Contractually agree to practice full-time (a minimum of 40 clinical hours per week);
- Complete and notarize the Affidavit of Lawful Presence in the United States (form provided), and submit a copy of a secure and verifiable document from the approved list.

APPLICATION PROCESS

All required information in the application must be complete before the Board will consider it. Completed applications must be received no later than **November 3rd** to be considered for funding during the fiscal year. Applications will not be considered complete unless **all** required materials, including completed Lender Disclosure Forms, are received by the deadline.

Contact the Board office for additional information. While it is not typically required, the Board may request that applicants make a personal appearance.

Applicants approved by the Board will receive a Notice of Award letter and an Acceptance of Award form. Upon receipt of the signed Acceptance of Award form, the Board will issue a **DRAA Program contract**. Payment of the award will be 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 in total loan repayment assistance. Each recipient is required to submit an annual status report to the Board.

CONTRACT DEFAULT

- The contract includes a penalty of **double the principal award amount received** for any of the following violations:
- Failure to begin or complete the full 12-month service commitment at the location specified in the contract;
- Failure to fulfill the full-time service requirement of at least 40 clinical hours per week (as defined in GBHCW Rules and Regulations – Chapter 195-14-.01(18));
- Failure to provide the Board with access to records and other information necessary to verify compliance

with the terms of the contract.

- In addition to the default penalty, attorney fees and other costs associated with collection will also be assessed.

FURTHER INFORMATION AND ASSISTANCE

If you have any questions, please click here to submit and we will respond back

Georgia Board of Health Care Workforce

2 MLK JR. DR, SE

11th Floor, East Tower

Atlanta, Georgia 30334

404-463-1057- Office

www.healthcareworkforce.georgia.gov

Georgia Board of Health Care Workforce

Dentists for Rural Areas Assistance Program

Application Cover Sheet

Please initial by each item signifying that it is enclosed. All materials must be returned under this cover sheet in one packet by November 3rd. Incomplete applications will not be considered.

Applicant's Name _____

Have you previously been a recipient of GBHCW Loan Repayment Program? __ Yes __ No

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 to Lender (Do Not Mail Original Lender Disclosure to GBHCW):

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

Miscellaneous:

_____I understand that my loan will be repaid as stated in the application, unless my loan servicer sells or transfers the loan to another lender.

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 3rd** may not be considered.

Applicant Signature_____Date_____

Print Applicant Name_____

DRAA Program

c/o GBHCW

2 MLK JR. DR, SE,

11th Floor, East Tower Atlanta, Georgia 30334

Georgia Board of Health Care Workforce

Dentists for Rural Areas Assistance Program

Loan Repayment Program Application

Please type or print CLEARLY in black or blue ink.

I. Personal Data

Full Legal Name:_____

Maiden Name(s) :_____ DOB:__/____/_____SSN:_____

Address: Must provide street address. No P.O. Boxes.

_____

City:_____County:_____

State:_____Zip Code:_____

Primary Phone:_____Secondary Phone:_____

Email: _____

II. Dental Specialties

☐ General Dentistry ☐ Oral Surgery ☐ Prosthodontics

☐ Pediatric Dentistry ☐ Endodontics ☐ Orthodontics

☐ Periodontics ☐ Other: _____

III. Dental Education

Dental School:_____Graduation Date:_____

City:_____State:_____

Clinical Site:_____

Degree Obtained: ☐ **DDS** ☐ **DMD** **Board Certified:** ☐ Yes ☐ No

Residency Hospital (if Applicable) : _____

City: _____ State:_____ Graduation Date:____/___/____

Residency Hospital: _____ Specialty:_____

City: _____ State:_____ Graduation Date:____/___/____

Georgia Dental License Number:_____ License Issue/Expiration Date: _____

Medicaid Provider Number: _____

IV.Practice Information

Applicant agrees to practice as a dentist, full-time, for one year at:

Practice Site Name:_____

Address:_____

City:_____County:_____Zip Code: _____

Number of clinical hours per week at this location: _____

Beginning date of practice:_____(This will not be the date service will commence) Total Annual Compensation:_____

Are you currently receiving any loan repayment assistance? ☐ 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: _____

Number of clinical hours per week at this location: _____

Beginning date of practice:_____(This will not be the date service will commence)

Total Annual Compensation:_____

Are you currently receiving any loan repayment assistance? ☐ Yes ☐ No

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

_____

***Include a copy of all contracts between yourself and your practice/employer(s)**

DRAA Loan Repayment Program

---------LENDER PAYMENT DISTRUBUTION FORM--------

Recipient: Payments of your award will be made directly to your lenders. Please use this form to specify which lender(s) receive payment up to your annual award amount of **$25,000**

RECIPIENT NAME: _____

Loan #1

_____
Full Name of Lending Institution

_____ _____
Contact Person (optional) Telephone Number

_____
Lender Payment Mailing Address City State Zip

#_____ #_____ $_____ $_____
Loan Account Number Loan ID Number Current Balance Amount toward repayment
Request Payment be Applied: **1. To Balance of Loan**
(Please Circle One Option) **2. To Principal Only**

Loan #2

_____
Full Name of Lending Institution

_____ _____
Contact Person (optional) Telephone Number

_____
Lender Payment Mailing Address City State Zip

#_____ #_____ $_____ $_____
Loan Account Number Loan ID Number Current Balance Amount toward repayment
Request Payment be Applied: **1. To Balance of Loan**
(Please Circle One Option) **2. To Principal Only**

Loan #3

_____
Full Name of Lending Institution

_____ _____
Contact Person (optional) Telephone Number

_____
Lender Payment Mailing Address City State Zip

#_____ #_____ $_____ $_____
Loan Account Number Loan ID Number Current Balance Amount toward repayment
Request Payment be Applied: **1. To Balance of Loan**
(Please Circle One Option) **2. To Principal Only**

IV. Questions

Please answer the following questions in 250 words or fewer.

1. Why did you choose to pursue a career in healthcare?

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

3. What excites you most about the future of rural dentistry?

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

V. 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 representation of 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 3rd.**

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 the original 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 Nursing education debt through the Dentists for Rural Areas Assistance 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 PROGRAM for all or the appropriate portion of the education loan listed above, incurred solely for the cost of Dental education, including reasonable living expenses 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

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_____.

_____
Legal Signature, Notary Public

(Place Seal Imprint Here)

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 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 "[n]ot 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.