Georgia Board of Health Care Workforce

James Barber, MD
BOARD CHAIRMAN

Chet Bhasin, FACHE
EXECUTIVE DIRECTOR

2 MLK JR Drive, 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 Georgia Board of Health Care Workforce **Georgia Behavioral Health Provider Loan Repayment Program** (GBHPLRP). 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 $150,000 to mental health or substance use professionals to repay outstanding education debt in return for practicing at a Health Professional Shortage Area (HPSA) in Mental Health as identified by the Health Resources and Services Administration (HRSA), a department of the U.S. Health and Human Services in underserved areas in Georgia. **Contracts are awarded for a four-year term.** The award amount varies based on behavioral occupation.

- Psychiatrists (MD/DO): $150,000
- Psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists who hold doctoral degrees in behavioral health: $80,000
- Clinical nurse social workers, licensed professional counselors, licensed specialists in school psychology, and licensed marriage and family therapists who do not hold doctoral degrees: $40,000
- Licensed chemical dependency counselors who hold associate degrees, or any other behavioral health licensee not listed above: $10,000

Please complete the attached GBHPLRP Application and submit it online at **GBHCW-LoanRepayment by November 1st, 2024.** 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
GBHPLRP LOAN REPAYMENT PROGRAM

PURPOSE OF THE PROGRAM

The purpose of the Georgia Behavioral Health Provider Loan Repayment Program (GBHPLRP) is to increase access to high-quality mental health or substance use professional care in underserved, rural communities in Georgia.

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

The GBHPLRP pays mental health or substance use professional's education student loan debt for those who agree to practice full time in a rural community in Georgia. The program provides up to $150,000 in student loan repayment in return for a 48-month commitment to practice in a Health Professional Shortage Area (HPSA). If the verified loan balance is less than the maximum award amounts below, the applicant will be awarded a lower amount of 25% of the loan balance each year for four years. The award amount varies based on behavioral occupation.

- Psychiatrists: $150,000
- Psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists who hold doctoral degrees in behavioral health: $80,000
- Clinical nurse social workers, licensed professional counselors, licensed specialists in school psychology, and licensed marriage and family therapists who do not hold doctoral degrees: $40,000
- Licensed chemical dependency counselors who hold associate degrees or any other behavioral health licensee not listed above: $10,000

The GBHPLRP contract requires a commitment to practice as a mental health or substance use professional for a minimum of 32 clinical hours per week in a Health Professional Shortage Area (HPSA) in Mental Health as identified by the Health Resources and Services Administration (HRSA), a department of the U.S. Health and Human Services in underserved rural areas in Georgia. Providing direct patient care during normal clinic hours at the approved practice site or other location required by the practitioner to provide care effectively. The remaining hours must be spent providing care to patients and/or in practice-related administrative activities. On-call hours are not considered part of the full-time requirement.

Funding is based upon the amount of funds appropriated to the Georgia Board of Health Care Workforce by the Georgia General Assembly.

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.

APPLICATION REQUIREMENTS

Eligible Applicants must:

- Be a citizen, legal resident, or foreign national of the United States;
- Licensed with no restrictions and in good standing to practice in Georgia by the Georgia Composite Medical Board or the appropriate licensing Board under the Georgia Secretary of State's Office ;
- Agree to practice full-time (a minimum of forty hours per week) in a Board-approved practice location in an unserved geographic area or community in Georgia designated by the Georgia Board of Health Care Workforce ;
- Must work in a qualifying practice that actively treats Medicaid or Peachcare patients ;
- Be in good standing with regard to meeting the contractual requirements of all existing student loans. Must not have other current contractual service obligations, such as National Health Service Corps Scholarships or Military Service Obligations ;
- Must have mental health or substance use professional education or undergraduate loans for repayment in good standing and must not have any loans in default status even if the creditor now considers the defaulted loan to be in good standing;
- Submit executed copy of all current employment contracts or a letter signed by organization HR official validating employment at organization;
- 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 the provided document list.

APPLICATION PROCESS

All information requested in the Application must be complete prior to Board consideration.

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 a GBHPLRP Loan Repayment Program contract. Payment of the Award is made once the contract is fully executed.

Each recipient is required to complete and submit an annual status report to the Board.

CONTRACT DEFAULT

The contract includes a penalty of double the principal award amount for unfulfilled service period received for:

- Failure to begin or complete the full forty eight-month service commitment at the location named in the contract;
- Failure to meet the 40 clinical hours per week full-time practice commitment (minimum of 40 clinical hours per week as defined in GBHCW Rules and Regulations - Chapter 195-16); or
- Failure to provide Board staff with access 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 double 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

GHBPLRP Loan Repayment 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:

_____GHBPLRP Application (pages 6-11), with proper notary signature

_____Authorization and Release Form (page 13), with proper notary signature

_____O.C.G.A. 50-36-1(e)(2) Affidavit (page 14), with proper notary signature

_____Copy of at least one secure and verifiable document (list provided on pages 15-16)

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

_____Lender Disclosure form(s) (page 12) 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_____

Georgia Board of Health Care Workforce

GHBPLRP Loan Repayment Program

Application

Please type or print CLEARLY in black or blue ink.

Which license applies to you? Select only one

____Psychiatrist (MD/DO only): $150,000
____Psychologists or any of the following that hold a Doctoral degree ARPNs, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists: $80,000
____Clinical nurse specialist in psychiatric/mental health: $40,000
____Licensed clinical social workers, licensed professional counselors, licensed specialist in school psychology, and licensed marriage and family therapists who do not hold doctoral degrees: $40,000
____Licensed chemical dependency counselors who hold associate degrees or any other behavioral health licensee not listed above: $10,000

I. Personal Data

Full Legal Name:_____

Address: _____

City:_____County:_____

State:_____Zip Code:_____

Primary Phone:_____Secondary Phone:_____

Email: _____

II. Education

Full Name of Institution:_____Graduation Date:_____

City:_____State:_____

Highest Degree Obtained: Please check which applies to you

____ High School
____ College
____ Graduate/Professional School
____ Post Graduate/ Professional Training
____ Additional Education
____ N/A
____ Other: Please write in _____

Georgia License Number : _____

Medicaid Provider Number: _____

IV. Practice Information

Applicant agrees to practice as a mental health or substance use professional, full-time, for four years at:

Practice Site Name:_____

Address:_____

City:_____County:_____Zip Code: _____

Additional Practice Information (if applicable):

Practice Site Name:_____

Address:_____

City:_____County:_____Zip Code: _____

Please provide your total compensation details for the current year:

1. **Base Salary (Annual or Hourly):**
   If you are paid hourly, please provide your hourly wage. If you are salaried, please provide your annual base salary.
   _____

2. **Bonuses or Incentives (if applicable):**
   Please specify any bonuses or other incentive compensation you received or expect to receive this year.
   _____

3. **Expected Total Compensation for Current Year:**
   Please provide the total amount you expect to earn this year, including salary, bonuses, and any additional compensation.
   _____

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

Short Essay Questions

Please answer the following questions in 250 words or fewer.

1) Please share what you enjoy the most about working in Mental Health/Substance Use?

2) Describe the patient population you treat as part of your practice/job?

V. Mental Health and Substance Use Professional Education Debt

Estimate of total outstanding educational 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 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. Mental Health and Substance Use Professional Education Debt

Estimate of total outstanding educational 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 disbursement;

5. Loan Holder:_____

Loan Holder Address: _____

City:_____State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

6. Loan Holder:_____

Loan Holder Address: _____

City:_____State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

7. Loan Holder:_____

Loan Holder Address: _____

City:_____State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

8. Loan Holder:_____

Loan Holder Address: _____

City:_____State:_____Zip Code: _____

Account Number:_____Loan Balance: $_____

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 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: _____

Georgia Behavioral Health Provider Loan Repayment Program

Outstanding 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

I hereby authorize the government or financial Institution named above to release this information to the Georgia Board of Health Care Workforce for purp Health Provider Loan Repayment 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 – GEORGIA BHAVIORAL HEALTH PROVIDER LOAN REPAYMENT PROGRAM for all or the appropriate portion of the education loan listed above, incurred solely for the cost of a mental health or substance use education, including reasonable living expenses associated with the degree.

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 professional education for mental health or substance use.

_____ _____

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 Georgia Behavioral Health Provider Loan Repayment 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

Georgia Behavioral Health Provider Loan Repayment grant to repay the cost of my tuition and other expenses while obtaining my 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 mental health or substance use 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 be 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: _____

Revised: October 2015

O.C.G.A. § 50-36-1(e)(2) Affidavit

By executing this affidavit under oath, as an applicant for the **Georgia Behavioral Health Provider 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 "[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.