2018-19 HPLRP Program Reference Guide

Health Professional Loan Repayment Program

The purpose of the Program Reference Guide is to provide information about applicant eligibility requirements, qualification factors, compliance, roles, and responsibilities. It is the responsibility of the applicant to **review this document prior to completing the online application.** Please feel free to print a copy of this document to use as a reference throughout the contract period.

Updated: 10/24/2017
Revised: 2/5/2018

Website: http://www.wsac.wa.gov/health-professionals
Email: health@wsac.wa.gov
Phone: 1-888-535-0747 Opt 5

TABLE OF CONTENTS

Section 1: General Information

Program Overview

The Washington State Health Professional Loan Repayment and Scholarship (HPLRS) program was established in 1989 to address health care workforce shortage issues in rural and underserved urban communities. There are two separate programs within this scope: the State Health Professional Loan Repayment Program (HPLRP) and the Federal-State Loan Repayment Program (FSLRP).

The programs are administered by the Washington Student Achievement Council (WSAC) in collaboration with the Department of Health (DOH), as authorized by RCW 28B.115. A planning committee provides expertise related to each member's professional field.

The loan repayment programs have helped to recruit and retain over 1,000 providers throughout the state. The programs provide funds to Recipients to pay toward their outstanding qualifying education loans.

The State Health Professional Loan Repayment Program (HPLRP) is funded with state dollars.

Recipients are required to work a minimum of three years at an eligible site. Recipients are allowed to work less than full time, but a minimum of 24 hours per week, which extends their service obligation period until they fulfill the equivalent of three years of full-time service. Awards are a maximum of $75,000 (not to exceed provider's actual loan debt).

Program definitions are located on page 25.

Application Process Overview

The Washington State Health Professional Loan Repayment Program has a two-step application process.

Step 1: Sites apply and request license types during the site application. WSAC approves and posts a list of eligible sites and provider types on its website.

Step 2: Providers apply during the provider application cycle. To be eligible to apply, providers must have an employment contract at an approved site that requested that license type.

Sites apply for eligibility on behalf of their providers. If a site did not apply during the site application cycle or did not request a particular license type, that site's providers would not be eligible to apply.

If you are a provider interested in participating in either loan repayment program, please contact your site representative.

Application Timelines	
October 2017	Site application opens (single application for both FSLRP and HPLRP).
December 8, 2017	Site application closes.
December 2017	Site receives notification of application request status. Approved list posted online.
January 2018	Provider application opens (single application for both FSLRP and HPLRP).
March 15, 2018	Provider application closes.
June 2018	WSAC begins notifying providers of award status
July 1, 2018	New contract awards for both programs begin. Providers must meet the eligibility requirements and be seeing patients at an approved site. *Exception: Residents may have a contract beginning October 1, 2018*

Eligible Disciplines and Specialties

Primary Care	
Disciplines	Specialty
Physician • Allopathic • Osteopathic • Naturopathic	• Family Medicine • General Internal Medicine • General Pediatrics • Obstetrics/Gynecology • Geriatrics
Physician Assistant Nurse Practitioner	• Adult • Family • Pediatric • Women's Health • Geriatrics
Certified Nurse Midwife Licensed Midwife	
Registered Nurse Licensed Practical Nurse	
Pharmacist	
Dental Care	
Disciplines	Specialty
Dentist • DDS • DMD	• General Dentistry • Pediatric Dentistry
Registered Dental Hygienist	
Behavioral & Mental Health	
Disciplines	Specialty
Physician • Allopathic • Osteopathic	• General Psychiatry • Child and Adolescent Psychiatry
Nurse Practitioner Physician Assistant	• Mental Health and Psychiatry
Licensed Independent Clinical Social Worker Licensed Clinical Psychologist Licensed Marriage and Family Therapist Licensed Mental Health Counselor	• Requires a full independent license. Individuals with the associate level, restricted credential are not eligible.

Eligible Site Types

Sites approved by the program are health care facilities that provide comprehensive outpatient, ambulatory, primary health care services. See example list below. To be approved, the site must submit an online application each year. Dates are posted on the WSAC website at www.wsac.wa.gov/health-professionals.

The following list includes examples of **eligible sites** but is not all-inclusive.

1. Federally Qualified Health Centers (FQHCs)
    - Community Health Centers (CHCs)
    - Migrant Health Centers
2. FQHC Look-Alikes
3. Centers for Medicare & Medicaid Services Certified Rural Health Clinics (RHCs)
4. Other Health Facilities
    - Community Outpatient Facilities
    - Community Mental Health Facilities
    - State and County Health Department Clinics
    - Free Clinics
    - Mobile Units
    - Critical Access Hospitals (CAH)
    - Rural Hospitals
    - Long-Term Care Facilities
    - State Mental Health Facilities
5. Indian Health Service Facilities
    - Federal Indian Health Service (IHS) Clinical Practice Sites
    - Tribal-Operated 638 Health Clinics
    - Urban Indian Health Program
6. Correctional Facilities
7. Private Practices (Solo or Group)
8. Urgent Care Clinic, if physically attached to an eligible site and used to see patients who cannot be scheduled for appointments or for after-hours and weekends. The clinic cannot be a stand-alone urgent care or walk-in clinic.

The following list includes examples of **ineligible sites** but is not all-inclusive.

- Hospitals that are not designated as Critical Access or rural
- Specialty clinics
- Placement/staffing agencies
- K-12 school-based clinics
- Clinics that see members only
- Non-state operated inpatient facilities
- Private Practice (Solo or Group) sites that serve less than 40% Medicare/Medicaid, Uninsured, Charity and Sliding Fee Schedule patients
- Stand-alone urgent care or walk-in clinics
- Hospital emergency departments

Comprehensive Primary Care

Comprehensive Primary Care (CPC) is a continuum of care not focused on or limited to gender, age, organ system, a particular illness, or categorical population (e. g. developmentally disabled or those with cancer). CPC should provide care for the whole person on an ongoing basis. If sites do not offer all primary health services, they must offer an appropriate set of primary health services necessary for the community or populations they serve. For example, a site serving a senior population would need to provide geriatric primary care services.

All sites must provide comprehensive primary care within the approved disciplines and specialties. For example, a dental facility would be required to offer comprehensive primary dental care services; an orthodontic practice would not meet the definition of comprehensive primary dental care, as it is not an approved specialty. Sites that focus their efforts on a particular population defined by disease or diagnosis are not considered CPC. For example, immunization clinics, substance abuse treatment centers, and HIV clinics are not eligible.

Nurses (RN and LPN) are included in this definition and should provide these services in collaborative teams in which the ultimate responsibility for patients resides with the primary care physician.

Pharmacists must be providing primary care to patients and working as a part of a care team. Patient care may be filling and dispensing prescriptions, monitoring medications, seeing patients, and coordinating care within the integrated health care team. Time spent on educational classes or working with specialty patients (such as warfarin, diabetes) would fall under the same eight-hour limitation as for other professions (see page #8 for hours' requirements).

Behavioral and mental health clinics must also provide comprehensive primary health services in an integrated setting/system of care. Comprehensive primary health services include, but are not limited to: screening and assessment; diagnosis; treatment plans; therapeutic services, including access to medication prescribing and management; crisis care, including 24-hour call access; consultative services; care coordination; and case management. Sites providing such services must function as part of a system of care to ensure continuity of patient-centered, comprehensive, and coordinated care. The site must also offer or ensure access to ancillary, inpatient, and specialty referrals. If a site does not provide all of these services they must demonstrate a formal affiliation with a comprehensive community-based primary behavioral health setting or facility to provide these services. Note: approved sites must provide the following core comprehensive primary services directly, not through affiliation or referral: screening and assessment, treatment plans, and care coordination and case management.

Non-Discrimination Notice

Approved sites must prominently display a statement—in a common area and, if applicable, on the site's website—that explicitly states that no one will be denied access to services due to method of payment or inability to pay. In addition, the signage should clearly communicate that the site accepts Medicare, Medicaid, and CHIP. (Free clinics are exempt from the Medicare, Medicaid, and CHIP statement.) The statement should be translated into the appropriate language(s) or dialect(s) for the service area.

Tribal Health Program Exception

At the request of a tribal health program, the services of a provider may be limited to tribal members or other individuals who are eligible for services from that Indian Health Program. However, tribal health programs are required to respond to emergency medical needs as appropriate.

Private Practices (solo or group) only

Please be aware that private practices may require a site visit before the application review is completed, and must meet a minimum threshold of 40% Medicare, Medicaid, uninsured, charity and Sliding Fee Schedule patients.

Service Requirements

Recipients must work a minimum of 24 hours per week. To qualify towards loan repayment, work hours **must be spent providing patient care at the approved site(s)** except for a limited number of "other" hours (see Table below) which may include performing patient care in alternate locations as directed by the approved site(s) or performing practice-related administrative activities. No more than 12 hours of work may be performed in any 24-hour period.

	Work hours per week	**Minimum work days per week**	**Maximum allowed "other" work hours**
Full-time	40	The 40 hours per week may be compressed into no less than four days a week.	All providers, except those listed below: 8 Obstetrics/gynecology*, certified nurse midwives, licensed midwives, geriatrics, and pediatric dentists: 19 (max 8 hours of administrative)
Less than full-time	24-39	The minimum 24 hours a week may be compressed into no less than two days a week.	All providers, except those listed below: 4 Obstetrics/gynecology*, certified nurse midwives, licensed midwives, geriatrics, and pediatric dentists: 11 (max 4 hours of administrative)

* including family medicine physicians who practice obstetrics on a regular basis

Providers working at an approved Critical Access Hospital-outpatient clinic pairing must work a minimum of 16 hours per week providing patient care at the clinic. This requirement applies to all providers at CAHs regardless of whether the provider works full time or less.

> **Exception:** RNs and Pharmacists working at CAH and Rural Hospitals may work all of their hours providing patient care in the hospital setting. Eligible RNs and Pharmacists must still meet the intent of comprehensive primary care and not be specialized to treat a particular population defined by disease or diagnosis.

Telemedicine may be considered patient care when both the originating site (location of the patient) and the distant site (the approved site where provider is working) are located in a federal Health Professional Shortage Area (HPSA). Telemedicine must be limited to not more than 25 percent of a provider's patient care hours.

Site Change Policy

Recipients are expected to complete their entire service commitment at the eligible loan repayment site(s) for which the application was submitted. Recipients who require changes to their eligible loan repayment site(s) must request approval of the new site in advance. All sites must be pre-approved and determined eligible by WSAC.

Recipients who have concerns about fulfilling their service obligation at their approved site are encouraged to contact program staff immediately to discuss options and receive prior approval to transfer or add to another approved site. A Recipient who leaves the approved site without prior approval may be placed in default.

The Recipient will not receive service credit for the time period between the last day providing patient care at the prior service site and resumption of service at the new site following approval. The Recipient may qualify for a suspension of service. If a Recipient who has not obtained prior approval begins employment at a non-approved site and refuses to relocate to an eligible site, the Recipient will be placed in default. It is the Recipient's responsibility to obtain employment at an approved site. A list of approved sites will be provided upon request.

A site change request may be approved if:

- The Recipient submits a written request prior to changing sites, and includes the following:
  1. A written statement from an authorized staff of each site (original and new) agreeing to the site change.
  2. Reasons for the site change request (brief statement).
  3. Dates of employment involved.
- The Recipient has complied with program requirements such as starting service on the agreed contract start date.
- The Recipient's license or certification has not been revoked, suspended, or restricted, and no disciplinary action is pending.
- The Recipient has not been terminated by the site for documented cause.
- The Recipient has worked a minimum of one pay period at the approved site as indicated on the Recipient's contract prior to request.

WSAC's approval of changes to the Recipient's eligible loan repayment site(s) does not alter any local employment contract requirements in any manner.

Any change or additions in eligible sites within the same health care organization (i.e., an organization or health care system with multiple delivery sites or satellites) is regarded as a change in the eligible loan repayment site(s) and must be approved in advance.

Section 2: Provider Eligibility and Program Information

Provider Eligibility Requirements

To be eligible, providers **must meet the following criteria**:

- Be a United States citizen, permanent resident, or be eligible to work in Washington State. (Please note: There is no Washington residency requirement for eligibility; however, providers should apply only if they are confident in their ability to fulfill the service requirement and avoid monetary repayment.)
- Work in an eligible profession and discipline type.
- Have and maintain a current, full, permanent, unrestricted, and unencumbered health professions license in Washington State for the entire duration of the service obligation period. An unencumbered license is not revoked, suspended, or made probationary or conditional by the state licensing authority as the result of disciplinary action.
- Be providing Comprehensive Primary Care (CPC). See definition on page 7.
- Be a permanent employee of the approved, eligible site(s) and have scheduled direct patient clinic/hospital/pharmacy hours. Provider may not be working on an as-needed or on-call basis, or as a float, without a regular predetermined schedule.
- Be employed at an eligible site and seeing patients no later than July 1, 2018. *Exception:* Providers who are still in residency status between July 1 and September 30, 2018 may have a contract start date no later than October 1, 2018. See Site Eligibility section.
- Agree to accept reimbursement under Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), as appropriate for the provider's designated discipline, and to see all patients regardless of their ability to pay.

To be eligible, providers **may not**:

- Have received an award through the Health Professional Scholarship Program or be a previous FSLRP/HPLRP Recipient. Previous Recipients cannot reapply.
- Not be in default on any education loans.
- Have an outstanding contractual obligation for health professional service to the federal government, or to a state or other entity, unless that service obligation will be completely satisfied before the effective date of the contract. NOTE: Certain provisions in employment contracts can create a service obligation (e.g., a recruitment bonus in return for a provider's agreement to work at that facility for a certain period of time or pay back the bonus). **Any kind of payback requirement in your contract is considered an obligation and will disqualify you from being eligible**, unless that requirement is satisfied, null, or void in writing.
    - Individuals in the Reserve Component of the U.S. Armed Forces or National Guard are eligible to participate in the HPLRP. If the participant's military training or service, in combination with the participant's site absences, exceed 40 workdays per service year, the service obligation will be extended to compensate for the break in service.

Examples of ineligible providers:

- A Public Health Nurse working outside of the clinic. Must be working as a clinical nurse with scheduled clinic hours in the ambulatory setting.
- A provider working at a stand-alone urgent care clinic, emergency department, specialty clinic, or through a placement agency.
- A provider hired to work in an administrative position, unless able to meet minimum hour requirements working in direct patient care (see minimum hour requirements by profession pg. 8).
- A provider who is currently under a contractual obligation, such as NHSC, that overlaps the HPLRP contract start date of July 1, 2018.

Eligible Loans

Qualifying educational loans include:

- Government and private (commercial) loans for actual costs paid for tuition and reasonable educational and living expenses related to the education of the Recipient for this licensure.

Loans that are not eligible include:

- Loans for which the associated documentation cannot identify that the loan was solely applicable to the undergraduate or graduate education of the applicant.
- Loans that have no current balance.
- Loans for which the provider incurred a service obligation that will not be satisfied prior to the start of HPLRP contract.
- Loans that have been consolidated with personal debt.
- Loans that have been consolidated with another person's loans (e.g. spouse, child's ParentPlus Loan that has been consolidated with yours). This makes the entire loan ineligible.
- Loans subject to cancellation (e.g., Perkins Loans may require documentation to confirm no cancellation through service).
- Loans for other educational degrees that were not required to obtain licensure in the profession you are applying under. If those loans were consolidated with an otherwise eligible loan, the entire loan ineligible.
- Primary Care Loans, as this is viewed as an obligation for health professional service to the federal government.
- Credit card debt or personal lines of credit.

Provider Program Information

Award Amounts and Disbursement

The maximum HPLRP award amount for the 2018-19 award cycle is $75,000, not to exceed the provider's loan debt. The contract is a minimum of three years and a maximum of five years.

- Awards are based on the loan debt balance submitted on the application and supported by lender statements.
- The funds are intended to reduce the debt by the award amount. It is not intended to pay the balance in full as interest continues to accrue.
- Awards will be divided into quarterly payments over the contract service obligation period.
- Credit is earned during the quarter. Payments are made after the completion of each quarter and upon receipt, review, and approval of the *Quarterly Service Verification Form*.
- Verification of payment on loan debt will be required periodically throughout the service obligation. Recipients will be asked to submit copies twice a year (in January and July) of their payment history from their lender(s) as documentation that all program funds were applied to their loan debt. Failure to document that all funds were applied will place the Recipient in repayment default.
- The loan repayment contract begins July 1. The Recipient is responsible for continuing all lender payments. Payment history tracking begins after the first check is issued, **not** the first day of the contract period.
- WSAC funds received must be fully applied, starting from the first disbursement date. These funds may not be used to reimburse any payments made prior to this date.
- Payments will be suspended during periods of approved suspension (for example, FMLA) and the service obligation will be extended accordingly. The Recipient will be required to complete a contract addendum for the suspension period.
- Payments will cease upon termination of employment. If you are approved for a transfer and re-employed at an eligible site, your payments will restart at the end of the next completed quarter. Upon approval, you will be paid for any pending payments from past quarters of service that were being held at that time.

Service Obligation

At the end of each quarter, the Recipient must submit a *Quarterly Service Verification Form* (available at www.wsac.wa.gov/health-professionals) reporting service hours worked. This is the document used to start the payment process.

- The site administrator is required to verify the hours worked; fax, mail, or scan and email a copy of the form; and retain the original copy.
- Quarters are January–March, April–June, July–September, and October–December.
- When requested, Recipients must send payment history from the lender(s) to verify that all loan repayment funds are being fully applied toward the approved educational lender(s).
- Recipients must be employed a minimum of 24 hours each week (may not average hours over a pay period).
- Recipients must not exceed eight weeks (the equivalent of approximately 40 eight-hour workdays) per service year (July 1–June 30) away from the approved service site for vacation, holidays, continuing professional education, illness, leave without pay, or any other reason.

Suspension of Service

Recipients are expected to fulfill their service obligation without excessive absences or significant interruptions in service. A suspension of the service obligation may be granted if the Recipient's compliance with the obligation is temporarily impossible or an extreme hardship (e.g., leave of absence for medical reasons, FMLA, or call to active duty). Suspensions should be requested in advance when possible and be pre-approved. Periods of approved suspension will suspend payments and extend the Recipient's service commitment end date.

Continuation Awards

Recipients may receive a continuation award; however, awards will be determined on a case-by-case basis, based on available funds and remaining eligible debt. You do not need to and are not able to submit a new application for a continuation award. Program staff will contact Recipients about continuation award opportunities.

Only those who work full time will be allowed to request extensions beyond their original three-year contract. **If you work less than full time, you will not be eligible for an extension.**

Other Information

- If you pay your loans in full before the end of your service obligation, your payments will cease, but your service obligation is not waived.
- The only permissible basis for canceling a contract is 100% total and permanent disability or death of the Recipient.
- The program will not be held responsible for principal or interest paid to any lender.
- Program funds are considered educational and cannot be discharged in a bankruptcy.
- Loan debt continues to accrue interest during the service obligation period. Program funds are intended to reduce the debt by not more than the award amount and may not pay the balance in full.
- Recipients who enlist in any of the Armed Forces and incur an active duty military obligation before completing their HPLRP obligation are subject to the default provision of their contracts.

Default Repayment

Recipients who breach their obligation will owe the State an amount equal to double the sum disbursed plus interest. This amount is due and payable immediately. WSAC may approve modified repayment terms.

Repayment Cost Examples

	Award Amount Disbursed	Repayment Amount	Interest Rate	Loan Term	Assumes a Monthly Payment of:	Total Paid (includes penalty and interest)
Example 1	$50,000	$100,000	4.5%	1 year	$8,537.86	$102,454.23
Example 2	$50,000	$100,000	8.6%	1 year	$8,726.61	$104,719.32
Example 3	$50,000	$100,000	9%	1 year	$8,745.12	$104,941.77
Example 4	$50,000	$100,000	12%	1 year	$8,884.85	$106,618.53

INTEREST RATES, PENALTIES, FEES AND COST EXAMPLES

The examples shown above are in the case of the Recipient going into repayment. Interest begins accruing on the principal balance when the Recipient goes into repayment status, the beginning interest rate will be determined at that point in time. The interest rate will be on the notification letter sent at the time of entering default repayment. You may contact WSAC for annual interest rates.

Interest rate during the life of the repayment

The interest rate is variable. This means the interest rate can be adjusted lower or higher than your beginning interest rate. Interest will be charged at the amount determined annually by WSAC and stated on the contract that you sign. The interest rate is updated each year on July 1.

Repayment fees

Repayment Financial Penalty: You are required to repay double the amount of funds disbursed to you if your account goes into default repayment. *Example:* If you received $25,000, you would be required to repay $50,000 plus interest.

Other fees

Late Fee: A late charge of 5% of the payment due may be charged on any payment received later than 20 days after the due date.

Insufficient Funds: Up to $50 *(does not include any fees charged by banks or other institutions)*.This applies to credit card, electronic fund transfers, ACH, checks, and any other type of payments made on your account that fail to clear due to insufficient funds.

Collection and Legal Fees: Any necessary expenses for collection of any amount not paid when due (to the extent permitted by law) including attorney's fees, whether or not legal proceedings have begun.

Section 3: Site Eligibility and Program Information

Site Eligibility Criteria

To be eligible, sites must meeting the following criteria:

- Provide Comprehensive Primary Care (see definition page 7).
- Charge for professional services at the usual and customary prevailing rates.
- Understand and agree that no aspect of the provider's employer-provided wage or benefit(s) will be reduced in any way as a result of the provider's receipt of the Health Professional Loan Repayment Program award.
- Have been in business and have patient data for a minimum of one year prior to submitting the site application.
- Accept assignment for Medicaid/Medicare beneficiaries and have entered into an appropriate agreement with the applicable state agency for Medicaid and CHIP beneficiaries.
- Use a provider credentialing process including reference review, licensure verification, and a query of the National Practitioner Data Bank (NPDB): http://www.npdbhipdb.hrsa.gov.
- Function as part of a system of care that either offers or assures access to ancillary, inpatient, and specialty referrals.
- Adhere to sound fiscal management policies and adopt provider recruitment and retention policies to help the patient population, the site, and the community obtain maximum benefits.

To be eligible, **sites must not:**

- Promise loan repayment to an employee or when recruiting for an employee. The provider application process is competitive and there are no guarantees that a provider will be awarded even if the site has been approved.
- Discriminate in the provision of services to an individual: a) because the individual is unable to pay; b) because payment would be made under Medicare, Medicaid, or the Children's Health Insurance Plan (CHIP); or c) based upon the individual's race, color, sex, national origin, disability, religion, age, or sexual orientation.

If the site has a payback clause of any kind in the employment agreement/contract (such as a sign-on bonus or moving expense allowance that has a payback clause if the provider leaves before a specified time) it will make the provider ineligible for the program, unless that obligation has been fulfilled prior to the effective date of the contract.

Federal HPSA Designation (Not Required for HPLRP Program)

A Federal Health Professional Shortage Areas designation is required for the FSLRP, but not HPLRP. A HPSA is designated by the Bureau of Health Workforce as having shortages of primary medical care, dental, or mental health providers, and may be a geographic area (e.g. county), a population group (e.g. low-income), a public or private nonprofit medical facility, or other public facility. In order to be designated as a HPSA, communities or facilities apply for designations by providing the required data an area, population, or facility. Applications are submitted through the State Primary Care Offices (PCO); additional information is provided below.

There are three HPSA categories: primary care, dental, and mental health. In addition to being designated as a HPSA, a community, population, or facility is scored on the degree of shortage that exists based on the same factors used in the designation process. HPSA scores range from 1 to 25 for primary care and mental health, and 1 to 26 for dental health. The numerical score provided for a HPSA reflects the degree of need (the higher the score, the greater the need).

Federally Qualified Health Centers (FQHC), FQHC Look-Alikes, Indian Health Service (IHS), and Tribal Clinics are automatically designated as being a facility HPSA, and **some** Rural Health Centers (RHC) that meet additional criteria **may be** automatically designated as a facility HPSA.

To apply for or request a HPSA designation, please contact your State PCO. State PCO contacts can be found at http://bhpr.hrsa.gov/shortage/hpsas/primarycareoffices.html. Applicants may also search for this information by state and county (http://hpsafind.hrsa.gov) or by site address (http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx).

Currently sites must have a HPSA score of 1 or higher to be eligible to apply for FSLRP; however, the actual HPSA score is not used in determining the site score used for approval.

Sliding Fee Schedule (preference given, but not required for HPLRP)

The Sliding Fee Schedule, or discounted fee schedule, is based upon the Federal Poverty Guidelines. Patient eligibility is determined by annual income and family size. Specifically, for individuals with annual incomes at or below 100% of the HHS Poverty Guidelines (see table below), approved sites should provide services at no charge or at a nominal charge. For individuals between 100% and 200% of the HHS Poverty Guidelines, approved sites should provide a schedule of discounts, which should reflect a nominal charge (see table below). To the extent that a patient who otherwise meets the above criteria has insurance coverage from a third party (either public or private), an approved site can charge for services to the extent that payment will be made by the third party.

FOR EXAMPLE USE ONLY:

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
	Charge					
Family Size	Nominal Fee ($5)	20% pay	40% pay	60% pay	80% pay	100% pay
1	0-$12,060	$12,061-$15,075	$15,076-$18,090	$18,091-$21,105	$21,106-$24,120	$24,121+
2	0-$16,240	$16,241-$20,300	$20,301-$24,360	$24,361-$28,420	$28,421-$32,480	$32,481+
3	0-$20,420	$20,421-$25,525	$25,526-$30,630	$30,631-$35,735	$35,736-$40,840	$40,841+
4	0-$24,600	$24,601-$30,750	$30,751-$36,900	$36,901-$43,050	$43,051-$49,200	$49,201+
5	0-$28,780	$28,781-$35,975	$35,976-$43,170	$43,171-$50,365	$50,366-$57,560	$57,561+
6	0-$32,960	$32,961-$41,200	$41,201-$49,440	$49,441-$57,680	$57,681-$65,920	$65,921+
7	0-$37,140	$37,141-$46,425	$46,426-$55,710	$55,711-$64,995	$64,996-$74,280	$74,281+
8	0-$41,320	$41,321-$51,650	$51,651-$61,980	$61,981-$72,310	$72,311-$82,640	$82,641+
For each additional person, add	$4,180	$5,225	$6,270	$7,315	$8,360	$8,360

*Based on 2017 Federal Poverty Guidelines.

Please Note: To meet the sliding fee discount eligibility criterion; your site must have an active/implemented Sliding-Fee Discount Schedule and a public notice of its availability for all patients conspicuously posted near the front desk or check-in area. The sliding fee schedule should be available for all eligible patients and be applicable to all services provided at your site. (e.g. pharmacies should have a separate SFS).

Site Program Requirements

The site must sign a Memorandum of Agreement outlining the site's responsibilities:

- The site assumes an obligation for the three-year contract period at the site where the Recipient applied and was approved. The site should take into consideration the Recipient's contract and obligation when looking at staffing changes.
    - If an organization has multiple sites, the Recipient cannot move or add an additional site without going through a pre-approved site change process.
- The site is responsible for reporting if the Recipient falls below the required 24 hours per week.
- The site is required to contact WSAC within five business days if the Recipient is terminated for any reason, has their license suspended, has a disciplinary action brought against them, or no longer has a valid license to practice.
- The site is required to submit a Quarterly Service Verification Form to verify the hours the Recipient worked. It is the site's responsibility to verify the hours and to retain the original copy of the form. The forms are reviewed during site visits.

Quarterly Service Verification Form

- The Quarterly Service Verification Form is posted on the WSAC website at www.wsac.wa.gov/health-professionals.
- The site is to verify the number of days the provider has been on any kind of paid or unpaid leave, vacation, holiday, sick, continuing education, leave without pay, or any other leave. It is the site's responsibility to let the provider know when they are nearing the 40-day maximum so they do not exceed it. If the provider exceeds the maximum limit, it will put them in default on their contract. The site is responsible for contacting WSAC if the provider exceeds, or is in jeopardy of exceeding, the limit.
- The site is to mail, email, or fax a scanned copy of the form to WSAC's office so a payment can be processed for the Recipient.
- The form must be signed by someone who has authority to verify the Recipient's hours.
- The form will not be accepted if it is signed or dated before the last day of the quarter.

Site Visits

WSAC program staff will conduct on-site visits to provide technical assistance, to answer questions, and to ensure compliance with program requirements. Once a date is agreed upon, staff may request documentation, policies on non-discrimination, sliding fee scale information, and the original copies of the provider's Quarterly Service Verification Forms.

During the site visit, staff may meet separately with the site administrator and the Recipients (either individually or in a group).

Interviews with the Recipients are a priority and are conducted with a dual focus of: 1) ensuring Recipients are meeting program requirements, and; 2) making certain they are integrating into the community and experiencing a rewarding practice setting.

The discussion with the site administrator is focused on how the site is meeting expectations and requirements. Using a standard site visit tool, staff will review program compliance and verify data submitted in the site application.

Section 4: Application Process

The Washington State Health Professional Loan Repayment Program has a two-step application process.

Step 1: Sites apply and request license types during the Site Application. WSAC approves and posts a list of eligible sites and provider types on its website.

Step 2: Providers apply during the provider application cycle. Providers must have an employment contract at an approved site that requested that license type to be eligible to apply.

Sites apply for eligibility on behalf of their providers. If a site did not apply during the site application cycle or did not request a particular license type, that site's providers would not be eligible to apply.

If you are a provider interested in participating in either loan repayment program, please contact your site representative.

Site Application

The site must log into the WSAC portal and select the site application they wish to update. If the site has never applied, or the site does not appear on the drop-down menu, site will need to contact WSAC to be added. Email health@wsac.wa.gov with site name, county and phone number. Staff will contact site for confirmation when it has been added.

New this year, sites will use **one application per physical location**. All provider types can be selected on that application. If you have a clinic that includes medical, dental, mental health, and/or a pharmacy at one location, you do not have to submit separate applications.

Only one user login per site application is allowed. If you cannot access your site's application, please contract program staff for assistance.

To apply, go to our website: www.wsac.wa.gov/health-professionals.

Required Information

Before you begin your application, you must have the following information available for each physical site:

- Individual site/clinic's legal name and address.
    - You will need a separate application for each physical location.
    - Be sure you use the zip code of the site/clinic's physical location—not the business office zip code—as this is used in the scoring process.
    - If you have completed a prior application, please verify the clinic name and address.
- Contact name, phone number, and email.
- Number of unduplicated patients for each individual site/clinic for the most recently completed calendar or fiscal year.
- Total underserved patient count: This includes the annual unduplicated number of active patients that are billed under Medicare, Medicaid (including managed care and fee for service), CHIP, uninsured (does not include private pay), charity, and sliding fee schedule. This number does not include write-offs due to inability to collect.
- Total all patient count: Total annual unduplicated active patients
- For each provider license type requested, provide the following:
    - Budgeted FTEs
    - Vacant FTEs
    - Filled FTEs
    - Retention requests FTEs
- You will be asked to look up the HPSA designation for each location by discipline (i.e., Medical, Dental and Mental Health) using the link provided in the application.
- You will be asked to look up your site's HPSA ID using the link provided in the application.
- You will be asked look up census tract data using the website link provided in the application.

Completing the Application

The site application must be completed by an authorized HR staff or other site personnel with appropriate authority to submit the application on behalf of the employer/organization. The provider is not allowed to complete the site application. Exception: a provider may complete the site application for a solo private practice they own.

- Complete and submit the online application by 5:00 p.m. on the established deadline.
- Review the application carefully before clicking the "submit" button to make sure all fields are completed.
- **Any applications that are missing documents will be considered incomplete and will not be reviewed**. Submit your application early; program staff may contact you to make corrections. (However, corrections and submissions are not accepted after the deadline.)
- Most program communication will be emailed. Please check your email for any messages we might send after you submit your application. Add health@wsac.wa.gov to your email contacts and check to make sure the messages don't go to your "junk mail."

Site Approval and Notification

The Site Application Cycle will open in October and close in November of 2017. Sites are notified of their eligibility status, and the Eligible Site List is posted on WSAC's website.

Required Attachments

The Washington Student Achievement Council may, at its discretion, request and consider additional documentation to ensure program compliance. This may include, but is not limited to, documentation of sliding fee scale policy, program signage, and documentation of integrated system of care.

Provider Application

Required Information

Before you begin the application, you will need to have the following information available:

- Site name and address.
- Site contact name, phone number, and email address.
- Copy of current lender statements showing lender names and current balances. **Lender statements must contain your name**.
- Name, dates, and degrees from colleges you have attended.
- Location and dates of residency, if applicable.
- Licensure information, date of license, and license number. Includes licenses from other states.
- Employment start date (month, day, and year). Use the date you began seeing patients, not the date you signed the contract. Use the date you began working using the license you are applying under.

Completing the Application

- Complete and submit the online application by 5:00 p.m. on the established deadline.
- Review the application carefully before clicking the "submit" button to make sure all fields are completed and all required documentation is uploaded.
- **Any applications that are missing documents or have incomplete information will be considered incomplete and will not be reviewed**. Submit your application early; program staff may contact you to make corrections. (However, corrections and submissions are not accepted after the deadline.)
- Notifications of award and non-award will go out by email. Please do not call the office to check on the status of your application prior to June 30.
- Most program communication will be emailed. Please check your email for any messages we might send after you submit your application. Check to make sure the messages don't go to your "junk mail."

Required Attachments

You will be asked to upload these documents to complete your application:

- **Current** loan statement(s) with outstanding educational debt amount.
  - Be sure to **include all eligible debt**. Once the application is submitted, you will not be able to add lenders or additional loan debt to your list.
  - Please submit the most current lender statement. Statement must show the lender name, your name, account balance, and date.
  - Debt must be related to obtaining licensure **for this profession only**. Do not include debt for other degrees or programs that do not support this license. You will not be able to submit loans that have been consolidated with loans for other degrees.
  - Do not submit promissory notes, school statements, etc.
  - Do not submit loans that can be cancelled by service. (e.g., Perkins Loans) They are not eligible.

- **Employment and Site Confirmation Form.** This form is located within the online application. This form must be completed and signed by the Authorized Site Designee, as well as by your direct supervisor. **Submit a separate form for each clinic at which you work.** Please check this form carefully before submitted to make sure there are no blank fields.

The Washington Student Achievement Council may, at its discretion, request and consider additional documentation regarding any response provided on this application. Failure to provide the requested additional documentation in the time requested may result in the disqualification of your application.

Section 5: Selection and Notification

Provider selection is based on:

- Criteria outlined in state Washington Administrative Code.
- Site criteria, including (but not limited to) geographic location, ratio of underserved patients, staffing criteria, and use of a sliding fee schedule.
- Provider funding priorities and shortage needs identified by the program's planning committee.

There is a limit of two awards per profession, per site, unless funds remain available. A portion of funds will be reserved for Psychiatrists and Psychiatric Advanced Registered Nurse Practitioners working at DSHS Eastern and Western State Hospitals.

WSAC will send out notifications to all applicants, whether selected or not.

Definitions

Alternative Setting
Alternative settings include any setting in a HPSA at which the clinician is directed to provide care by the approved site (e.g., hospitals, nursing homes, and shelters). The alternative setting must provide services to a HPSA that is appropriate for the discipline and specialty of the clinician and the services provided. Services at alternative settings must be an extension of the comprehensive primary care provided at the approved site.

Ambulatory Setting
Ambulatory care or outpatient care is medical care provided on an outpatient basis, including diagnosis, observation, consultation, treatment, intervention, and rehabilitation services.

Clinical Administrative, Management, or other Activities
May include charting, care coordination activities, training, laboratory follow-up, patient correspondence, attending staff meetings, and activities related to maintaining professional licensure and other non-treatment related activities pertaining to the Recipient's approved site. Any time spent in a management role is also considered to be an administrative activity. The duties of a medical director are considered primarily administrative, and Recipients serving in such a capacity should keep in mind that they cannot count more than 8 hours per week of administrative and/or management time.

Commercial or Private Student Loans
Also known as college loans, educational loans, or alternative student loans. These are non-Government loans made by a private lender specifically for graduate or undergraduate education expenses, such as tuition, room, board, books, and other associated educational costs. These loans are made by banks, credit unions, savings and loan associations, insurance companies, schools, and other financial or credit institutions which are subject to examination and supervision in their capacity as lenders by an agency of the United States or of the State in which the lender has its principal place of business. These are unsecured loans with various options for repayment and may offer forbearance and deferral options.

Comprehensive Primary Behavioral and Mental Health Services
Services that include, but are not limited to: screening and assessment, diagnosis, treatment plans, therapeutic services including access to medication prescribing and management, crisis care including 24-hour call access, consultative services, care coordination, and case management. Sites providing such services must function as part of a system of care to ensure continuity of patient-centered, comprehensive, and coordinated care. The site must also offer or ensure access to ancillary, inpatient, and specialty referrals.

Comprehensive Primary Care
The delivery of preventive, acute, and chronic primary health services. Approved primary care specialties are adult, family, internal medicine, general pediatric, geriatrics, general psychiatry, mental and behavioral health, women's health, and obstetrics/gynecology. CPC is a continuum of care not focused on or limited to gender, age, organ system, a particular illness, or categorical population (e. g. developmentally disabled or those with cancer). CPC should provide care for the whole person on an ongoing basis. If sites do not offer all primary health services, they must offer an appropriate set of primary health services necessary for the community or populations they serve.

Critical Access Hospital (CAH)
A facility certified by Centers for Medicare and Medicaid Services (CMS) under section 1820 of the Social Security Act. WSAC recognizes the entire CAH as a service delivery site, including the Emergency Room (ER), swing bed unit, and skilled nursing facility (SNF). The CAH must provide comprehensive primary care and related inpatient services. The CAH must also demonstrate an affiliation with an outpatient, primary care clinic, either through direct ownership or affiliation agreements. Both the CAH and affiliated primary care clinic must submit separate site applications during the same application cycle and certify compliance.

Correctional Facility
Clinics within state or federal prisons. Clinical sites within county and local prisons are not eligible. Federal prisons are clinical sites that are administered by the U.S. Department of Justice, Federal Bureau of Prisons (BOP). State prisons are clinical sites administered by the state.

Federal Health Professional Shortage Area (HPSA)
A geographic area, population group, public or nonprofit private medical facility, or other public facility determined by the Secretary of HHS to have a shortage of primary health care professionals. HPSAs may be identified on the basis of agency or individual requests for designation. Information considered when designating a primary care HPSA include health provider to population ratios, rates of poverty, and access to available primary health services. HPSAs are designated by the Office of Shortage Designation, within HRSA's Bureau of Health Professions, pursuant to Section 332 of the PHS Act (Title 42, U.S. Code, Section 254e) and implementing regulations (Title 42, Code of Federal Regulations, Part 5).

Federally-Qualified Health Centers (FQHC)
FQHCs include: (1) nonprofit entities that receive a grant (or funding from a grant) under section 330 of the Public Health Service (PHS) Act (i.e., health centers); (2) FQHC "Look-Alikes," defined below; and (3) outpatient health programs or facilities operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act.

FQHC Look-Alike
Health centers that have been identified by the Health Resources and Services Administration (HRSA) and certified by the Centers for Medicare and Medicaid Services as meeting the definition of "health center" under Section 330 of the PHS Act, although they do not receive grant funding under Section 330. More information is available at http://bphc.hrsa.gov/about/apply.htm.

Free Clinic
A medical facility offering community health care on a free or very low-cost basis. Care is generally provided in these clinics to persons who have lower or limited income and no health insurance, including persons who are not eligible for Medicaid or Medicare. Almost all free clinics provide care for acute, non-emergent conditions. Many also provide a full range of primary care services (including preventive care) and care for chronic conditions.

Full Time Equivalent (FTE)
A time-based unit that measures the workload of an employee. A permanent employee that was employed to work a minimum of 40 hours per week would be 1.0 FTE. Someone who works 32 hours a week would be .8 FTE. Likewise an employee working 20 hours a week would be .5 FTE.

Health Centers
HRSA funds health centers in communities, providing access to high-quality, family-oriented, comprehensive primary and preventive health care for people who are low income, uninsured, or living where health care is scarce. Health centers are public and private nonprofit health care organizations that comply with federal requirements to: 1) Serve a medically underserved population, 2) provide appropriate and necessary services with fees adjusted on patients' ability to pay, 3) demonstrate sound clinical and financial management, and 4) be governed by a board, a majority of which includes health center patients. Health Center Awardees use federal grant funding to offset the costs of uncompensated care, enabling services and other operational costs.

HPSA ID
The main identifier for a HPSA as a complete unit in the source data system. Found at: http://datawarehouse.hrsa.gov/GeoAdvisor/ShortageDesignationAdvisor.aspx

Health Resources and Services Administration (HRSA)
An operating agency of Health and Human Services (HHS).

Indian Health Service (IHS) Hospitals
A collective term that includes hospitals that are both IHS-owned and IHS-operated, or IHS-owned and tribally-operated (i.e., a federal facility operated by a tribe or tribal organization contracting with the IHS pursuant to the Indian Self-Determination and Education Assistance Act), which provide both inpatient and outpatient clinical treatment services to eligible American Indians and Alaska Natives. This term does not include hospitals that are both tribally-owned and tribally operated.

Indian Health Service, Tribal or Urban Indian Health Clinic (ITU)
A health care facility—operated directly by the Indian Health Service; or by a tribe or tribal organization contracting with the Indian Health Service pursuant to the Indian Self-Determination and Education Assistance Act, codified at 25 U.S.C. 450 et seq.; or by an urban Indian organization receiving funds under Subchapter IV of the Indian Heath Care Improvement Act, codified at 25 U.S.C. 1651 et seq.—which provides clinical treatment services to eligible American Indians and Alaska Natives on an outpatient basis.

Integrated Setting/System of Care – The care that results from a practice team of primary care and behavioral health clinicians working with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

Memorandum of Understanding
For the purpose of both the HPLRP and the FSLRP programs, it is the document that outlines the roles and responsibilities of the health site and WSAC. It is signed and agreed to by both parties.

Mobile Units/Clinics
Medical vehicles (e.g. mobile health vans) that travel to underserved rural and urban communities, providing primary care services to individuals located in a HPSA. Providers working within a mobile unit that functions as part of an approved site or through an alternative care setting (e.g. hospitals, nursing homes, shelters, etc.) will receive service credit for direct patient care, so long as the mobile unit is affiliated with an approved site and provides services to only the approved HPSA.

Non-Discrimination Notice
A prominently displayed statement or poster in common areas (and on the site's website, if applicable) that explicitly states that no one will be denied access to services due to method of payment or inability to pay, and that discounts are available based on family size and income. In addition, the signage should clearly communicate that the site accepts Medicare, Medicaid, and CHIP. The statement should be translated into the appropriate languages and/or dialects for the service area.

Non-Discrimination Policy

Sites must agree not to discriminate in the provision of services to an individual because the individual is unable to pay; because payment for those services would be made under Medicare, Medicaid, or CHIP; or based upon the individual's race, color, sex, national origin, disability, religion, age, or sexual orientation. All WSAC-approved sites must have written policies that clearly state that the site abides by these requirements.

Non-profit
"Non-profit private entity means an entity which may not lawfully hold or use any part of its net earnings to the benefit of any private shareholder or individual and which does not hold or use its net earnings for that purpose" (42 C.F.R. 62.52). For-profit health facilities operated by nonprofit organizations must follow the same guidelines as all other FSLRP sites.

Primary Care Offices (PCOs)
State-based offices that provide assistance to communities seeking HPSA designations. PCOs work collaboratively with Primary Care Associations, and the NHSC Program, to increase access to primary and preventive health care and to improve the status of underserved and vulnerable populations.

Primary Health Services
Health services regarding family medicine, internal medicine, pediatrics, obstetrics and gynecology, dentistry, or mental health that are provided by physicians or other health professionals.

Public Health Department Clinic
Primary or mental health clinics operated by state, county or local health departments.

Public Hospital
A public hospital or government hospital is a hospital that is owned by a government and receives government funding.

Private Hospital
A private hospital is a hospital owned by a for-profit company or a nonprofit organization, and privately funded through payment for medical services by patients themselves, by insurers, or by governments through national health insurance programs.

Rural
RCW 82.14.370 was revised to include a rural county definition based on population density. In this legislation, "rural county" was defined as "a county with a population density less than 100 persons per square mile." Subsequent legislation expanded the definition to include "a county smaller than two hundred twenty-five square miles."

Rural Health Clinic (RHC)
A facility certified by the Centers for Medicare and Medicaid Services under section 1861(aa)(2) of the Social Security Act that receives special Medicare and Medicaid reimbursement. RHCs are located in a non-urbanized area with an insufficient number of health care practitioners and provide routine diagnostic and clinical laboratory services. RHCs have a nurse practitioner, a physician assistant, or a certified nurse midwife available to provide health care services not less than 50 percent of the time the clinic operates. There are two types of RHCs:

- Provider-Based: affiliated with a larger healthcare organization that is a Medicare certified provider.
- Independent: generally stand-alone clinics.

Sliding Fee Scale (SFS) or Discounted Fee Schedule
A set of discounts that is applied to a practice's schedule of charges for services, based upon a written policy that is non-discriminatory. For detailed requirements for FSLRP Program Guides.

Solo or Group Private Practice
A clinical practice that is made up of either one or many providers, in which the providers have ownership or an invested interest in the practice. Private practices can be arranged to provide primary medical, dental and/or mental health services, and can be organized as entities on the following basis: fee-for-service, capitation, a combination of the two, family practice group, primary care group, or multi-specialty group.

Site Underserved Patient Count
The annual unduplicated number of active patients that are billed under Medicare, Medicaid (including managed care and fee for service), CHIP, uninsured (does not include private pay), charity, and sliding fee schedule. This number does not include write-offs.

Specialty Care/Services
A health care professional whose practice is limited to a particular area, such as a branch of medicine, surgery, or nursing; especially, one who by virtue of advanced training is certified by a specialty board as being qualified to so limit his or her practice.

Tribal Health Program
An Indian tribe or tribal organization that operates any health program, service, function, activity, or facility that is funded, in whole or part, by the IHS through, or provided for in, a contract or compact with the IHS under the Indian Self-Determination and Education Assistance Act (25 USC 450 et seq.).

Urgent Care Center
Urgent Care Centers provide acute episodic care on a walk-in basis to assist patients with an illness or injury that does not appear to be limb or life threatening and is beyond either the scope or availability of the typical primary care practice.

Washington State Department of Health
The Department of Health was formed in 1989 to promote and protect public health, monitor health care costs, maintain standards for quality health care delivery, and plan activities related to the health of Washington citizens. The Secretary of Health is appointed by the Governor. The statutory authority for the Department of Health is in the Revised Code of Washington 43.70.020.