

2017-18 Health Professional Loan Repayment Program EMPLOYMENT AND SITE CONFIRMATION FORM

This form is to be completed by the appropriate designees and uploaded as part of the online provider application.
For more detailed information, consult the 2017-18 FSLRP and HPLRP Site and Provider Reference Guides.

1. Provider Name:	2. Provider is a Permanent Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No
3. Employment Start Date: <i>Date provider began/will begin seeing patients at approved site</i>	4. Full Time Equivalent (FTE): <i>Example: 32 hours per week = 0.8 FTE</i>
5. Provider's Job Title:	6. License Type: <i>Example: MD, DO, NP</i>
7. Site Name: Will the provider be working at an additional approved site? <input type="checkbox"/> No <input type="checkbox"/> Yes <i>If yes, attach a <u>separate sheet</u> for each site.</i>	
8. Site Address: <i>Physical location where provider will work.</i>	City: _____ Zip: _____
9. How many unduplicated patients does/will this provider see annually? _____ <i>For Pharmacists – how many unduplicated patients' prescriptions do they fill?</i>	

<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider provides specialty care. <i>If yes, explain:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	For mental health providers: does your facility provide an integrated setting/system of care? <i>If no, explain:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider has an employment contract. <i>If yes, upload a signed/dated copy with this completed form.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Did provider receive or will provider be receiving a sign-on bonus, moving expense allowance, or any other funds—including funds to pay on educational loans—that have to be repaid if the provider leaves employment prior to a specific date? <i>If yes, explain:</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider provides care to patients at this site by speaking in a language other than English. <i>If yes, languages used:</i> <i>Does not include the use of interpreter.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Site is a public or nonprofit private entity located in and providing health care services in an HPSA (Health Professional Shortage Area). <i>For-profit facilities operated by nonprofit organizations must follow same guidelines as other FSLRP sites.</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	Provider is working in an HPSA that corresponds to their training and/or discipline. <i>For example, psychiatrists and other mental health providers must serve in a mental health HPSA.</i>

<input type="checkbox"/> Yes <input type="checkbox"/> No	The site uses a schedule of fees or payments that is consistent with locally prevailing wages or charges, and that is designed to cover the site's reasonable cost of operations.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The site uses a discounted/sliding fee schedule to ensure that no one who is unable to pay will be denied access to services.
<input type="checkbox"/> Yes <input type="checkbox"/> No	The site does not 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.

I certify that I have read the Site Reference Guide(s) and understand the site's responsibilities while participating in the Health Professional Loan Repayment Program.
Reference Guides located at: www.wsac.wa.gov/health-professionals

I acknowledge that the provider named above has made a commitment to stay at this facility for a minimum of two years (FSLRP contract) or a minimum of three years (HPLRP contract) while participating in the Health Professional Loan Repayment Program.

I certify and understand that it is the site's responsibility to validate that the provider works and meets the program's minimum hours each week during the service quarter and to submit the Quarterly Service Verification Form with an authorized signature.

I certify and understand that the site is to retain the original copy of the Quarterly Service Verification Form and may be required to provide the form during a site visit by WSAC staff.

I certify that the site will notify the loan repayment program staff of any changes to the provider's employment status or work location, or of substantial changes to job duties, within five business days.
Provider must submit and be approved for any site transfers—even within your organization—prior to changing job sites. Failure to do so will place the provider in repayment default.

Authorized Site Designee Signature:		Date:
Printed Name:	Title:	
Phone Number:	Email:	

Direct Supervisor's Signature:		Date:
Printed Name:	Title:	
Phone Number:	Email:	