



Washington Health Corps Reference Guide

State Health Program

Behavioral Health Program

Federal Health Program

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

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Section 1: General Information

Program Overview

The original Washington State Health Professional Loan Repayment and Scholarship program was established in 1989 to address health care workforce shortage issues in rural and underserved urban communities. Most recently, there were two separate programs within this scope: the State Health Professional Loan Repayment Program (HPLRP, now known as SHP) and the Federal State Loan Repayment Program (FSLRP, now known as FHP).

Washington Health Corps was established by the 2019 Legislature as an umbrella under which the current state health program (SHP) exists and the new behavioral health program (BHP) will exist. Under Washington Health Corps, WSAC also administers the federal health program (FHP), which is a federal grant–state match program. In exchange for service at an eligible site, the programs repay all or a portion of participants' outstanding educational loans. Since 1990, the programs have helped to recruit and retain over 1,000 providers throughout the state.

The Washington Student Achievement Council (WSAC) administers the programs in collaboration with the Department of Health (DOH), as authorized by [RCW 28B.115](#). A planning committee assists WSAC in developing criteria for selection of participants, and expertise related to each member's professional field.

Though the three Washington Health Corps programs are similar in many regards, there are important distinctions between the State (SHP), Behavioral (BHP), and Federal (FHP) programs that affect participant eligibility, service requirements, contract length, and award amount.

Throughout this guide, differences between the three programs are highlighted with color blocking, as seen below: blue for SHP and BHP and orange for FHP.

State Health Program (SHP) & Behavioral Health Program (BHP)

The State Health Program (SHP) and the Behavioral Health Program (BHP) are funded with state dollars. SHP and BHP participants are required to work at least 24 hours per week at a preapproved site. The service obligation term is three years for full-time employment (40 hours a week), or a prorated equivalent term of up to five years for less than full-time employment. Awards are a maximum of \$75,000 (not to exceed participant's actual loan debt).

Federal Health Program (FHP)

The Federal Health Program (FHP) matches state funds with federal funds from the U.S. Dept. of Health and Human Services – State Loan Repayment Program. Washington State received a new four-year federal matching grant beginning in 2018. FHP participants are required to work full time (a minimum of 40 hours per week) for a minimum of two years at a preapproved site. Awards are a maximum of \$70,000 (not to exceed participant's actual loan debt).

Program definitions are located in Section 7, beginning on page 21.

Program Updates and Announcements

Washington Health Corps has made several changes over the course of the last year. For the most up-to-date information about program changes, or the status of our application and awarding process, please visit the program webpage at wsac.wa.gov/health.

Comprehensive Primary Care – Definition & Requirements

Program rules require that participants be providing Comprehensive Primary Care (CPC) through primary medical care, behavioral/mental health services, and/or dental services. CPC is a continuum of care not focused on or limited to gender, age, organ system, a particular illness, or categorical population (e.g., individuals who have developmental disabilities, or people 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 CPC within the approved disciplines and specialties. For example, a dental site 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.

Behavioral/mental health clinics must provide comprehensive primary behavioral/mental health care services in an integrated system of care. 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; and care coordination. 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.

Discipline-Specific Guidelines

Nurses (RN in FHP, RN and LPN in SHP) 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 11 for hours requirements).

Non-Discrimination Policy

Sites may 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. All WSAC-approved sites must have written policies that clearly state that the site abides by these requirements. Participating sites must also post a notice of non-discrimination, as detailed on page 4.

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.

Section 2: Site Eligibility and Program Information

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 preapproved, the site must submit a preapproval application every three years. A site's preapproval status lasts for three years, contingent upon the site continuing to meet minimum qualifications. Dates for the site preapproval application, as well as other timeline-specific notifications, are posted on the WSAC website at www.wsac.wa.gov/health.

The following list includes examples of eligible site types **but is not all-inclusive**. In addition to being one of these types, the site must meet all other eligibility criteria outlined below:

1. Federally Qualified Health Centers (FQHCs)
 - Community Health Centers (CHCs)
 - Migrant Health Centers
2. Centers for Medicare & Medicaid Services Certified Rural Health Clinics (RHCs)
3. Indian Health Service Facilities
 - Federal Indian Health Service (IHS) Clinical Practice Sites
 - Tribal-Operated 638 Health Clinics
 - Urban Indian Health Program
4. 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.
5. Hospitals that meet program-specific requirements as follows:
 - **SHP & BHP:** Must be a Critical Access Hospital or Rural Hospital.
 - **FHP:** Must be a Critical Access Hospital that is affiliated with a qualified outpatient clinic.
6. 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.
7. Correctional Facilities
8. Long-Term Care Facilities
9. Other Health Facilities
 - Community Outpatient Facilities
 - Community Mental Health Facilities
 - State and County Health Department Clinics
 - Free Clinics
 - Mobile Units
 - State Mental Health Facilities

The following list includes examples of **ineligible sites for SHP, BHP, and FHP** but is not all-inclusive.

- Specialty clinics
- Placement/staffing agencies
- K-12 school-based clinics
- Clinics that see members only
- Non-state operated inpatient facilities
- Stand-alone urgent care or walk-in clinics
- Hospitals that do not meet the definition in #5 above
- Private practice sites that serve less than 40% Medicare, Medicaid, uninsured, charity, and sliding fee schedule patients

Site Eligibility Criteria

Please note: **Additional FHP-specific criteria** are listed beginning on page 5.

To be eligible, sites must meet the following criteria:

- Provide Comprehensive Primary Care (see page 2) and function as part of a system of care that either offers or ensures access to ancillary, inpatient, and specialty referrals.
- Understand and agree that no aspect of the participant's employer-provided wage will be reduced in any way as a result of the participant's receipt of the SHP, BHP, or FHP award.
- Have been in business and have patient data for a minimum of one year prior to submitting the site application.
- Use a provider credentialing process including reference review, licensure verification, and a query of the [National Practitioner Data Bank \(NPDB\)](#).
- 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.
- Charge for professional services at the usual and customary prevailing rates, unless a Free Clinic.
- Agree to accept assignment for Medicaid/Medicare beneficiaries and have entered into an appropriate agreement with the applicable state agency for Medicaid and CHIP beneficiaries.
- Sites may 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.
- 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) and/or dialect(s) for the service area. Please see page 2 for more information regarding the non-discrimination policy.
- 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 applicant will be awarded even if the site has been preapproved.
- If a 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.

Additional FHP Site Eligibility Criteria

- Be a public entity, a nonprofit private entity, or a for-profit health facility operated by a nonprofit organization. Per 42 C.F.R. 62.52, nonprofit 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."
- Provide discounts for individuals with limited incomes (i.e., use a sliding fee schedule).
- Be located in federally designated Health Professional Shortage Area (HPSA) or have a HPSA designation (score greater than zero).

Federal HPSA Designation (Not Required for SHP or BHP Program)

A federal Health Professional Shortage Area (HPSA) designation is required for FHP. A HPSA is designated by the Bureau of Health Workforce as having shortages of primary 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 on 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). Currently sites must have a **HPSA score of 1 or higher** to be eligible to apply.

Federally Qualified Health Centers (FQHCs), 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 the Washington Department of Health Primary Care Office at 360-236-2800 or ruralhealth@doh.wa.gov, or [visit their website](#). Applicants may also search for this information [by state and county](#) or by [site address](#).

Sliding Fee Schedule

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 on page 6), 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 on page 6). 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. Note: Qualifying SHP and BHP sites are not required to have sliding fee schedules; however, sites with sliding fee schedules may be given preference.

To meet the sliding fee discount eligibility criterion, the site must have an implemented sliding fee discount schedule and a public notice of its availability for all patients clearly 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 the site (for example, pharmacies should have a separate sliding fee schedule).

(cont. next page)

Sliding Fee Schedule, cont.

For example use only:

Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)												
Poverty Level*	100%	110%	120%	130%	140%	150%	160%	170%	180%	190%	200%	>200%
Family Size	DISCOUNT											
	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
1	\$12,140	\$13,354	\$14,568	\$15,782	\$16,996	\$18,210	\$19,424	\$20,638	\$21,852	\$23,066	\$24,280	\$24,281
2	\$16,460	\$18,106	\$19,752	\$21,398	\$23,044	\$24,690	\$26,336	\$27,982	\$29,628	\$31,274	\$32,920	\$32,921
3	\$20,780	\$22,858	\$24,936	\$27,014	\$29,092	\$31,170	\$33,248	\$35,326	\$37,404	\$39,482	\$41,560	\$41,561
4	\$25,100	\$27,610	\$30,120	\$32,630	\$35,140	\$37,650	\$40,160	\$42,670	\$45,180	\$47,690	\$50,200	\$50,201
5	\$29,420	\$32,362	\$35,304	\$38,246	\$41,188	\$44,130	\$47,072	\$50,014	\$52,956	\$55,898	\$58,840	\$58,841
6	\$33,740	\$37,114	\$40,488	\$43,862	\$47,236	\$50,610	\$53,984	\$57,358	\$60,732	\$64,106	\$67,480	\$67,481
7	\$38,060	\$41,866	\$45,672	\$49,478	\$53,284	\$57,090	\$60,896	\$64,702	\$68,508	\$72,314	\$76,120	\$76,121
8	\$42,380	\$46,618	\$50,856	\$55,094	\$59,332	\$63,570	\$67,808	\$72,046	\$76,284	\$80,522	\$84,760	\$84,761
For each additional person, add	\$4,320	\$4,752	\$5,184	\$5,616	\$6,048	\$6,480	\$6,912	\$7,344	\$7,776	\$8,208	\$8,640	\$8,640

Site Program Requirements

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

- The site assumes an obligation for the participant's program contract period. The site should take into consideration the participant's contract and obligation when looking at staffing changes.
- If an organization has multiple sites, the participant cannot move or add an additional site without going through a preapproved site change process.
- The site is responsible for reporting if the participant falls below the required contract hours per week.
- The site is required to contact WSAC within five business days if the participant 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 participant worked. It is the site's responsibility to verify the hours and to retain the original copy of the form. The participant should also retain a copy of the original form. WSAC may review forms during site visits.

Quarterly Service Verification Form: Site Responsibility

- The *Quarterly Service Verification Form* is available at www.wsac.wa.gov/health.
- The site is to verify the number of actual hours worked by the participant.
- A site administrator with authority must verify the participant's hours and sign the form.
- WSAC will not accept forms signed or dated before the last day of the quarter.

Site Visits

WSAC program staff may conduct on-site visits to provide technical assistance, answer questions, and ensure compliance with program requirements. Staff may request documentation, policies on non-discrimination, sliding fee schedule information, and the original copies of the participant's *Quarterly Service Verification Forms* for review during the site visit. During the site visit, staff may meet separately with the site administrator and with participants (individually or in a group).

Section 3: Provider Eligibility and Program Information

Provider Eligibility Requirements

To be eligible, providers must meet the following criteria:

- Work in an eligible profession, and if applicable, an eligible specialty (see pages 9-10).
- 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.
- Apply under the licensure for which the majority of their work is done (if dually licensed).
- Be employed at an eligible site and seeing patients no later than the first day of their contract start date (July 1).
- Be working at the application site at the time of contract start date. If the provider changes sites prior to award, they are no longer eligible for an award.
- Be a permanent employee of the preapproved, 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. Pharmacists may not be working in a “fill center.”
- Be providing Comprehensive Primary Care (see definition on page 2).
- Meet the minimum hours requirements of the program (see page 11).
- Agree to accept reimbursement under Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP), as appropriate for the participant’s designated discipline, and to see all patients regardless of their ability to pay.
- Not have a Primary Care Loan through the Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions.
- Not 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 (for example, a recruitment bonus in return for a provider’s agreement to work at that site for a certain period of time or pay back the bonus). **Any kind of payback requirement in a contract is considered an obligation and will disqualify the provider**, 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 FHP. If the participant’s military training or service, in combination with the participant’s site absences, exceed the allowed time away from the site per service year, the service obligation will be extended to compensate for the break in service.

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.

Additional Provider Eligibility Requirements – SHP & BHP

- Be a United States citizen or permanent resident or be eligible to work in Washington State.
- Not have accepted an award through the Health Professional Conditional Scholarship Program or be a previous FHP/SHP participant, if program funds were received or if the contract was breached. (If no funds have been disbursed at the time of termination, the participant is considered an early withdrawal and remains eligible to reapply for SHP.)

Additional Provider Eligibility Requirements – FHP

- Be a United States citizen or naturalized citizen.
- Work in a HPSA that corresponds to their training and/or discipline. For example, psychiatrists and other mental health providers must serve in a mental health HPSA.
- Not have accepted an award through the Health Professional Conditional Scholarship Program or be a previous FHP/SHP participant, regardless of whether program funds were received. Previous participants cannot apply.
- Not have a current default on any federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, federal income tax liabilities, Federal Housing Authority (FHA) loans, etc.), even if the creditor now considers them to be in good standing.
- Not have breached a prior service obligation to the federal/state/local government or other entity, even if they subsequently satisfied the obligation.
- Not have had any federal or non-federal debt written off as uncollectible or received a waiver of any federal service or payment obligation.
- Not have a judgment lien(s) against property for a debt to the United States.

Examples of ineligible providers for all programs:

- 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 hours requirements working in direct patient care (see minimum hours requirements by profession on page 12).
- A provider who is currently under a contractual obligation, such as NHSC, that overlaps the SHP, BHP, or FHP contract start date of July 1.

SHP

Eligible Disciplines and Specialties

Disciplines	Specialties
Physician <ul style="list-style-type: none">• Allopathic• Osteopathic• Naturopathic	<ul style="list-style-type: none">• Family Medicine• General Internal Medicine• General Pediatrics• Obstetrics/Gynecology• Geriatrics• General Psychiatry• Child and Adolescent Psychiatry
Physician Assistant Nurse Practitioner	<ul style="list-style-type: none">• Adult• Family• Pediatric• Women's Health• Geriatrics• Mental Health and Psychiatry
Certified Nurse Midwife Licensed Midwife	
Registered Nurse Licensed Practical Nurse	
Pharmacist	
Chiropractor	
Dentist <ul style="list-style-type: none">• DDS• DMD	<ul style="list-style-type: none">• General Dentistry• Pediatric Dentistry
Registered Dental Hygienist	
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.

BHP

Eligible Disciplines and Specialties

Disciplines	Specialties
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.

FHP

Eligible Disciplines and Specialties

Disciplines	Specialties
Physician <ul style="list-style-type: none">• Allopathic• Osteopathic	<ul style="list-style-type: none">• Family Medicine• General Internal Medicine• General Pediatrics• Obstetrics/Gynecology• Geriatrics• General Psychiatry• Child and Adolescent Psychiatry
Physician Assistant Nurse Practitioner	<ul style="list-style-type: none">• Adult• Family• Pediatric• Women's Health• Geriatrics• Mental Health and Psychiatry
Certified Nurse Midwife	
Registered Nurse	
Pharmacist	
Dentist <ul style="list-style-type: none">• DDS• DMD	<ul style="list-style-type: none">• General Dentistry• Pediatric Dentistry
Registered Dental Hygienist	
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.

Section 4: Obligations and Provider Awards

Award Amounts and Disbursement

SHP & BHP Award Amount and Contract Period

The maximum SHP and BHP award amount is \$75,000, not to exceed the participant's loan debt. This award requires full-time employment as a primary care health professional at a preapproved site for a minimum of three years, or less than full-time employment for a prorated equivalent term of up to five years. The loan repayment contract begins July 1.

FHP Award Amount and Contract Period

The maximum FHP award amount is \$70,000, not to exceed the participant's loan debt. This award requires full-time employment as a primary care health professional at a preapproved site for a minimum of two years. The loan repayment contract begins July 1.

Awards are based on the loan debt balance submitted on the application and verified by lender statements.

- The funds are intended to reduce the debt by the award amount. The award 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.
- Service credit is earned during the quarter. Payments are made after the completion of each quarter and upon receipt, review, and approval of each *Quarterly Service Verification Form*.
- Participants are required to periodically submit loan documentation verifying they have applied program funds to their eligible loan debt. The loan payment documentation must come from the lender and include the lender(s)'s name, the participant's name, and the date and amount of each payment made. Participants who fail to adequately document that all program funds were applied as stipulated in their contract will enter into repayment default status.
- Payment history tracking begins after the first check is issued, not the first day of the contract period. The participant is responsible for continuing all lender payments.
- WSAC funds must be fully applied, starting from the first disbursement date. The participant may not use funds to reimburse any payments made prior to this date.
- Payments will be suspended during periods of approved deferment (e.g., FMLA, medical leave), and the service obligation will be extended accordingly.

Program Service Requirements

To qualify toward loan repayment, work hours must be spent providing direct patient care, except for a limited number of "other" hours.

Direct patient care is defined as the direct delivery of healthcare services to a patient. Direct patient care hours must occur during normally scheduled clinic hours at a preapproved site(s).

- **Teaching activities hours – for full-time participants only:** to count toward direct patient care hours, requires participants to provide clinical education to students and residents in their area of expertise. The clinical education may: (1) Be conducted as part of an accredited clinical training program; or (2) Include the clinical supervision of a student/resident that is required in order for that student/resident to receive a license under state law.

Other hours may include providing direct patient care in alternative locations as directed by the preapproved site(s) or performing practice-related administrative activities.

The percentage of weekly work hours that must be spent on direct patient care depends upon profession, as detailed in the table below:

	Minimum percentage of direct patient care hours per week	Maximum percentage of other hours per week
For all professions, except those listed below	80%	20%
Obstetrics/gynecology (including family medicine physicians who practice obstetrics on a regular basis, certified nurse midwives, and licensed midwives), geriatrics, and pediatric dentists	52%	48% (with administrative activities not to exceed 20% of total weekly hours)

Participants may receive credit for up to 40 hours of work per week; overtime beyond the 40-hour work week does not count toward fulfilling the service obligation. In addition, no more than 12 hours of work may be performed in any 24-hour period.

SHP & BHP Minimum Hours Requirement

Participants have the option to work full time or less than full time but must work a minimum of 24 hours per week.

FHP Minimum Hours Requirement

Participants must work a minimum of 40 hours per week.

Time spent “on call” does not count toward the minimum hours requirement, except for those hours where direct patient care is provided as substantiated by the employer.

Rural and Critical Access Hospitals

Participants working at an approved Rural Hospital or Critical Access Hospital-outpatient clinic pairing must work a minimum of 40% of hours providing patient care at the clinic and a maximum of 60% of hours providing patient care at the hospital.

- **Exception:** RNs and Pharmacists working at Rural Hospitals or CAHs may work all of their hours providing direct patient care in the hospital setting. 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

Telemedicine may be considered direct patient care when both the originating site (location of the patient) and the distant site (the approved site where participant is working) are located in rural settings. Telemedicine must be limited to no more than 25% of a provider’s patient care hours.

Quarterly Service Verification Form: Provider Responsibility

At the end of each quarter, the participant must submit a *Quarterly Service Verification Form* (available at www.wsac.wa.gov/health) reporting service hours worked. This form documents service details by quarter, including hours worked, and begins the payment process.

- **Both the participant and the site administrator are responsible for verifying both the quarterly hours worked and hours spent away from the site by signing the *Quarterly Service Verification Form*. The site and participant verify this information on or after the last day of the quarter that the service form is documenting.**
 - Quarters are July–September, October–December, January–March, and April–June.
 - When requested, participants must send payment history from the approved lender(s) to verify that all loan repayment funds have been applied by the end of the quarter in which the funds were received.
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- **SHP & BHP:** Participants must work a minimum of 24 hours per week for a minimum of 44 weeks per year.
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- **FHP:** Participants must not exceed 7.14 weeks (**285.6 hours**) per service year (July 1–June 30) away from the preapproved service site for vacation, holidays, continuing professional education, illness, leave without pay, or any other reason.

Deferment of Service

Participants must fulfill their service obligation without extended absences or significant interruptions in service. A deferment of the service obligation may be granted if the participant'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). Deferments should be requested in advance and be preapproved. Periods of approved deferment will suspend payments and may extend the participant's service obligation end-date.

Award Extensions

Award extensions are determined annually based on availability of funds. Extension contracts are offered upon the successful completion of the initial contract. Participants who accept an extension receive an additional year of loan repayment in exchange for one year of ongoing employment at their preapproved site(s).

Participants do not apply for extensions. Program staff will contact participants about continuation award opportunities. Both the site and participant must continue to meet program requirements to be considered for award extensions.

Site Change Policy

All program participants must complete their entire service commitment at the preapproved site(s) under the submitted provider application. There may be circumstances when a participant and health shortage area would benefit from a site change. Participants must seek preapproval to request to transfer to a new site or to add a site, regardless of whether the sites are within the same health care organization (i.e., an organization or health care system with multiple delivery sites or satellites). **Failure to obtain approval prior to leaving the preapproved site may result in default on the loan repayment contract.**

Approval Criteria for a Site Change:

- Participant is in compliance with their contract.
- Participant's license or certification has not been revoked, suspended, or restricted, and no disciplinary action is pending.
- Participant has not been terminated by the site for documented cause.
- Participant has worked a minimum of one pay period at current site prior to request.
- New site is an approved site for loan repayment at the time of the transfer approval.

The participant will not receive service credit during the gap in service between the last day providing patient care at the prior service site and resumption of service at the transfer site. The participant will also not receive credit for any time spent working at a new site prior to receiving approval. The participant may qualify for a deferment of service for the gap in service time.

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

Participant Preapproval Process

To request to transfer to a new site or to add a site:

1. Participant must submit a request for the change, in advance.
2. If a signed Memorandum of Agreement (MOA) is not already on file, WSAC will require one for the new site.
3. WSAC will require a signed Contract Amendment for the participant.

Participants 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 add or transfer to another preapproved site. It is the participant's responsibility to obtain employment at a preapproved site.

Participants who are interested in learning more about recruitment resources should review the Washington State Department of Health, Office of Community Health Systems, [Rural Health Section](#) website. They provide direct recruitment services, assist with loan repayment programs, and coordinate the J-1 Visa Waiver Program.

Default Repayment

When a participant defaults on the terms of their service obligation as detailed in their signed contract, a penalty is assessed. **A default or breach for purposes of these programs is defined as failure to:** complete service obligation, accept Medicare/Medicaid/CHIP assignment, meet service requirements, or apply program funds to repayment of approved educational loan balances and provide documentation.

SHP & BHP Default Repayment

Participants who breach their obligation will owe the State an amount equal to the unsatisfied portion of the service obligation or the total amount paid on their behalf, whichever is less, plus interest, in addition to costs associated with collection of the debt. *(cont. next page)*

SHP & BHP Default Repayment, cont.

SHP & BHP Repayment Cost Examples

	Original Award Amount	Amount Received by Participant	Remaining Service Obligation Amount	Interest Rate	Total Amount Due for Repayment (Includes interest)
Ex. 1	\$15,000.00	\$8,000.00	\$7,000.00	4.53%	\$7,317.10
Ex. 2	\$35,000.00	\$25,000.00	\$10,000.00	4.53%	\$10,453.00
Ex. 3	\$50,000.00	\$10,000.00	\$40,000.00	4.53%	\$10,453.00
Ex. 4	\$75,000.00	\$50,000.00	\$25,000.00	4.53%	\$26,132.50

The examples shown above are in the case of the participant going into repayment. Interest begins accruing on the principal balance when the participant goes into repayment status. The beginning interest rate will be determined at that point in time. The interest rate will parallel the rate set for primary federal student loans for undergraduate students. The interest rate will be on the notification letter sent at the time of entering default repayment. The interest rate is variable. This means the interest rate can be adjusted lower or higher than the beginning interest rate. The interest rate is updated each year on July 1. Contact WSAC for annual interest rates.

FHP Default Repayment

Participants who breach their obligation have **one year** to repay debt and will owe the State an amount equal to **the sum of the following**:

- The total of the amounts paid to, or on behalf of, the participant for loan repayments for any period of obligated service not served.
- An amount equal to the number of months of obligated service not completed multiplied by \$7,500, except that the amount the State is entitled to recover shall not be less than \$31,000.
- Interest on the above amounts at the maximum legal prevailing rate (fixed rate), as determined by the Treasurer of the United States, from the date of breach.

FHP Repayment Cost Examples

	Financial Penalty	Repayment Amount (before interest is assessed) Minimum of \$31,000	Interest Rate	Loan Term*	Monthly Payment:	Total Paid (includes penalty and interest)
Ex. 1	3 months x \$7,500 = \$22,500	\$31,000	10%	1 year	\$2,725.40	\$32,704.67
Ex. 2	12 months x \$7,500 = \$90,000	\$90,000	10%	1 year	\$7,912.43	\$94,949.14
Ex. 3	12 months x \$7,500 = \$90,000	\$90,000	8.25%	1 year	\$7,839.37	\$94,072.40
Ex. 4	24 months x \$7,500 = \$180,000	\$180,000	10%	1 year	\$15,824.86	\$189,898.33

*Contract requires the participant to repay the loan in one year

(cont. next page)

FHP Default Repayment, cont.

The examples shown above are in the case of the participant going into repayment. Interest begins accruing on the principal balance when the participant goes into repayment status, with the interest rate determined at that point in time. The interest rate will be on the notification letter sent at the time of entering default repayment.

Other FHP, SHP, and BHP 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 the 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 fees, regardless of whether legal proceedings have begun.

Other Information

- Program funds are considered educational and may not be discharged in a bankruptcy.
- The program is not responsible for principal or interest paid to any lender.
- If the participant pays off loans in full before the end of the service obligation, payments to the participant will cease, but the service obligation is not waived.
- A participant may request a contract termination by submitting a written request for termination and repaying all funds disbursed under the contract no later than 45 days prior to the end of the fiscal year in which the contract was entered. Terminating the contract may disqualify the participant from reapplying or participating in other loan repayment programs.
- Outside of the limited termination opportunity, the only permissible basis for canceling a contract is 100% total and permanent disability or death of the participant.
- Loan debt continues to accrue interest during the contract period. Program funds are intended to reduce the debt by not more than the award amount, and may not pay the balance in full.
- Participants who enlist in any of the Armed Forces and incur an active duty military obligation before completing their contract obligation are subject to the default provision of their contracts.
- Individuals in a Reserve component of the Armed Forces, including the National Guard, are eligible to participate in the program. Military training or other duty performed by reservists will not satisfy the SHP, BHP, or FHP service commitment.

Section 5: Application Process

The programs use an application process consisting of three connected steps: site preapproval, provider application, and site certification. This streamlined process, outlined below, requires only minimum qualification information from sites until a provider application associated with their site is submitted.

Step 1: Sites apply and request preapproval status. WSAC reviews site applications and posts a list of preapproved sites on the WSAC website. Site preapproval status lasts for three years, contingent on the site continuing to meet minimum qualifications.

Step 2: Providers apply during the provider application cycle. To be eligible for consideration, providers must be working at a preapproved site, or have an employment contract to start work at a preapproved site on or before July 1.

Step 3: Sites certify the information submitted on the provider's application and provide additional details about the physical site.

Any provider interested in participating in either loan repayment program should contact their site representative. Participation in the program begins with a site preapproval.

Tentative Application Timeline	
Check announcements box at top of webpage for current status and timeline updates.	
Continuous	Site pre-approval application. Single application for SHP, BHP, and FHP.
Rolling notifications	Sites are notified of pre-approval status. Approved list posted online. Site preapproval must be completed by the close of the provider application for the provider to be eligible for that award cycle.
February	Provider application opens. Single application for SHP, BHP, and FHP.
March–May	Site certification: When providers apply under preapproved sites, site representatives receive notification to provide further detail.
June	WSAC begins notifying providers of award status.
July 1	New contracts begin.

Additional application information is available at wsac.wa.gov/health.

Site Preapproval Application

The site must submit an online application for site preapproval. Sites should submit **one application per physical location**. If a clinic includes medical, dental, mental health, and/or a pharmacy at one location, the site does not have to submit separate applications. An authorized HR staff or other site personnel with appropriate authority to submit the application on behalf of the employer/organization is to complete the site application. The site representative is the point of contact for important program communications.

Providers are not to complete the site application, except in the case of applying for a solo private practice owned by the provider.

Information Needed for the Site Preapproval Application

Before beginning an application, the following information must be available for each site:

- Individual site/clinic's legal name and address.
 - A separate application is required for each physical location.
 - A zip code is required for the site/clinic's physical location, and for the parent organization, if applicable.
- Contact name, phone number, and email.
- Physical location's nine-digit Unified Business Identifier (UBI) number and four-digit location code, which can be looked up on the [Department of Revenue](#) website.

Site Preapproval and Notification

Sites are notified of their preapproval status after completion of their Site Preapproval Application. The Preapproved Site List will be posted on WSAC's website.

Required Attachments

WSAC 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 schedule policy, program signage, and documentation of integrated system of care.

Provider Application

Complete and submit the online application by 5:00 p.m. on the established deadline.

- Any applications that are missing documents or have incomplete information will be considered incomplete after the deadline and will not be reviewed.
- Site preapproval must be completed by the close of the provider application for the provider to be eligible for that award cycle.
- Notifications of award and non-award, as well as all general program communication, will go out by email. If the email address provided changes after completion of the application, it is the provider's responsibility to notify program staff.

Information Needed for the Provider Application

The list below is information that will be required to complete the provider application. Please check our website for a sample of the provider application.

- Copy of current lender statements (see detailed instructions in the attachments section below).
- Colleges attended, including names, dates, and degrees.
- Location and dates of clinical residency, if applicable.
- Licensure information, date of license, and license number under which provider will be practicing.
- The date (day/month/year) provider began or will begin seeing patients at application site, using the license under which the provider is applying.
- Patient care hours per week.
- Annual patient count.

Required Attachments

The provider will be asked to upload these documents to complete the application:

- Current loan statement(s) with outstanding educational debt amount.
 - Please submit the most current lender statement, no older than 30 days. Statement must show the lender name, the provider's name, account balance, and date.
 - Be sure to **include all eligible debt** (loan eligibility is detailed in the following section). Additional lenders or debt cannot be added after the application is submitted.
 - Do not submit promissory notes, school statements, etc.

WSAC 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 disqualification of the application.

Eligible Loans

Qualifying educational loans include:

- Government and commercial loans for actual costs paid for tuition, and reasonable educational and living expenses related to the education of the applicant for this licensure.
- Loans related to obtaining licensure **for this profession only**.

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

Site Certification

The site certification step is to be completed by a site representative, only after the site has been preapproved and a provider has applied under the site for loan repayment. Sites will be asked to verify employment specifics for each provider that applies under the site. Site representatives will also provide site information beyond the minimum qualifications of the site preapproval application.

Section 6: Selection and Notification

The selection of program participants is designed to ensure that the program is meeting its intent. The SHP, BHP, and FHP are intended to address critical health care access and delivery shortages across the State of Washington by recruiting and retaining primary health care professionals to provide service to the state's rural and underserved urban populations. The SHP engages a statewide planning committee whose responsibilities include assisting with the selection of participants and revisiting the selection priorities to reflect the current needs of the state.

Selection is based on:

- Criteria outlined in Washington Administrative Code.
- Funding priorities and shortage needs identified by the program's planning committee.
- Site criteria may include (but are not limited to) geographic location, ratio of underserved patients, staffing criteria, and use of a sliding fee schedule.
- Provider criteria may include (but are not limited to) background, experience, and commitment.
- Legislative directives.
- Consideration of the distribution of awards across sites and professions.

SHP Only: A portion of funds will be reserved for psychiatrists and advanced registered nurse practitioners working at DSHS Eastern and Western State Hospitals.

WSAC will notify all applicants about the status of their selection for the program. Selection is tentatively scheduled to begin in May, and the process of awarding generally takes a few months to complete. The timeframe can vary depending upon the volume of applications received, the time it takes providers to accept or decline offers, and the number of rounds it takes to fully expend the funds. Applicants should check the website regularly during the awarding process for status updates.

Section 7: Definitions

Approved 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.

Care Coordination

For purposes of these programs, Care Coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care.

Clinical-Related Administrative, Management, or other Activities

May include charting, care coordination activities training, laboratory follow-up, patient correspondence, attending staff meetings, activities related to maintaining professional licensure, and other non-treatment related activities pertaining to the participant'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 participants 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 nongovernmental 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 that 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/ 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 (CPC)

The delivery of comprehensive primary medical care, behavioral/mental health, and/or dental services; Approved primary care specialties are adult, family, internal medicine, general pediatric, geriatrics, general psychiatry, 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., individuals with developmental disabilities, or people 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.

Comprehensive Community-Based Primary Behavioral Health Setting or Facility

A site that provides comprehensive primary behavioral health care services. The site must function as part of a system of care to ensure continuity of patient-centered, comprehensive, and coordinated care. The site must offer or ensure access to ancillary, inpatient, and specialty referrals.

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. The CAH and affiliated primary care clinic must each be approved program sites.

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 includes 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, and 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 on the [HRSA website](#).

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.

HPSA ID

The main identifier for a HPSA as a complete unit in the source data system. Found on the [HRSA website](#).

Health Resources and Services Administration (HRSA)

An operating agency of the U.S. Department of Health and Human Services (HHS).

Integrated Care

Team-based care provided to individuals of all ages, families, and their caregivers in a whole-person oriented setting or settings by licensed primary care providers, behavioral health clinicians, and other care team members working together to address one or more of the following: mental illness, substance use disorders, health behaviors that contribute to chronic illness, life stressors and crises, developmental risks/conditions, stress-related physical symptoms, preventative care, and ineffective patterns of health care utilization.

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 Health 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.

Local Health Jurisdictions (Departments/Districts)

Washington has 31 county health departments, three multi-county health districts, and two city-county health departments. These are referred to as local health jurisdictions. They are local government agencies, not satellite offices of the state Department of Health or the State Board of Health. Local health jurisdictions carry out a wide variety of programs to promote health, help prevent disease, and build healthy communities. The DOH website provides [links to local health jurisdiction websites](#).

Memorandum of Agreement

For the purposes of SHP, BHP, and FHP, 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 language(s) and/or dialect(s) 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.

Nonprofit

Nonprofit 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 FHP 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 National Health Service Corp 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 owned by a government and receives government funding.

Private Hospital

A private hospital is 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 Schedule (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 FHP eligibility, please refer to page 6.

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 so as to limit his or her practice.

Telemedicine

The delivery of telemedicine services uses an interactive telecommunications system, defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient at the originating site and the provider at the distant site. Telephones, fax machines, and electronic mail systems do not meet the definition of an interactive telecommunications system.

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 RCW 43.70.020.