



**APPLICATION FOR THE MISSOURI HEALTH
 PROFESSIONAL LOAN REPAYMENT PROGRAM**

SECTION 1 – APPLICANT’S PERSONAL INFORMATION				
APPLICANTS LAST NAME		FIRST NAME	MI.	APPLICANTS SOCIAL SECURITY NUMBER
OTHER NAMES USED			EMAIL ADDRESS	
DATE OF BIRTH	GENDER <input type="checkbox"/> M <input type="checkbox"/> F	HOME TELEPHONE NUMBER	CELL PHONE NUMBER	
<input type="checkbox"/> MARRIED <input type="checkbox"/> SINGLE <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED			AGES OF DEPENDENTS	
HOUSEHOLD INCOME FROM MOST RECENT INCOME TAX RETURN (AGI) (INDICATE TAX RETURN YEAR USED)				
PRESENT ADDRESS	STREET	CITY	STATE	ZIP
COUNTY	LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH			US CITIZEN <input type="checkbox"/> YES <input type="checkbox"/> NO
LAST NAME OF SPOUSE		FIRST NAME	MI.	SPOUSE SOCIAL SECURITY NUMBER
NAME OF RELATIVE NOT LIVING WITH YOU			RELATIONSHIP TO YOU	
RELATIVE STREET ADDRESS	CITY	STATE	ZIP	RELATIVE HOME TELEPHONE NUMBER

ADDITIONAL INFORMATION FOR REPORTING PURPOSES (OPTIONAL)				
RACE				
<input type="checkbox"/> WHITE	<input type="checkbox"/> JAPANESE	<input type="checkbox"/> HAWAIIAN	<input type="checkbox"/> OTHER PACIFIC ISLANDER	
<input type="checkbox"/> AFRICAN-AMERICAN	<input type="checkbox"/> ASIAN INDIAN	<input type="checkbox"/> SAMOAN	<input type="checkbox"/> OTHER _____	
<input type="checkbox"/> AMERICAN INDIAN	<input type="checkbox"/> KOREAN	<input type="checkbox"/> FILIPINO	HISPANIC ORIGIN?	
<input type="checkbox"/> CHINESE	<input type="checkbox"/> VIETNAMESE	<input type="checkbox"/> GUAMAN	<input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION 2 – APPLICANTS EMPLOYMENT INFORMATION				
EMPLOYER	STREET ADDRESS	CITY	STATE	ZIP
COUNTY	WORK TELEPHONE AND EXTENSION	SUPERVISORS NAME	EMAIL	
APPLICANT’S TITLE	DATE EMPLOYED	THIS FACILITY IS <input type="checkbox"/> PUBLIC <input type="checkbox"/> NON-PROFIT <input type="checkbox"/> FOR PROFIT		
____ HOURS WORKED PER WEEK _____ % DIRECT PATIENT CARE			DO YOU SEE PATIENTS REGARDLESS OF ABILITY TO PAY <input type="checkbox"/> YES <input type="checkbox"/> NO	

SECTION 3 – APPLICANTS SCHOOL/RESIDENCY PROGRAM INFORMATION				
LAST SCHOOL ATTENDED		RESIDENCY PROGRAM (IF APPLICABLE)	DATE COMPLETED (MMDD/YYYY)	
OF LIST BELOW, INDICATE THE DEGREE EARNED AND THE COMPLETION DATE				
<input type="checkbox"/> DIPLOMA NURSING DEGREE	<input type="checkbox"/> DOCTOR OF ALLOPATHIC MEDICINE			
<input type="checkbox"/> ASSOCIATE NURSING DEGREE	<input type="checkbox"/> DOCTOR OF OSTEOPATHIC MEDICINE			
<input type="checkbox"/> BACHELOR NURSING DEGREE	<input type="checkbox"/> DEGREE IN DENTAL SCIENCES			
<input type="checkbox"/> MASTER OF NURSING DEGREE	<input type="checkbox"/> RESIDENCY _____ (TYPE)			
<input type="checkbox"/> ADVANCED NURSE PRACTITIONER				
<input type="checkbox"/> DOCTORATE NURSE (Ph.D., D.N.P or Ed.D.)				
MEDICAID PROVIDER NUMBER			MEDICARE PROVIDER NUMBER	
ARE YOU A BOARD CERTIFIED PHYSICIAN? <input type="checkbox"/> YES <input type="checkbox"/> NO	BOARD CERTIFICATION NUMBER	MISSOURI LICENSE NUMBER		
LIST ANY OTHER STATES WHERE YOU ARE LICENSED TO PRACTICE AND YOUR LICENSE NUMBER				

APPLICATION FOR THE MISSOURI HEALTH PROFESSIONAL LOAN REPAYMENT PROGRAM

MUST BE TYPED OR PRINTED

SECTION 4 – EDUCATIONAL DEBT INFORMATION

DO YOU HAVE AN EXISTING SERVICE OBLIGATION? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, DATE TO BE COMPLETED	ARE YOU IN DEFAULT OF THIS OBLIGATION? <input type="checkbox"/> YES <input type="checkbox"/> NO
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NAME OF PROGRAM	TELEPHONE NUMBER
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HAVE YOU EVER DEFAULTED ON A STATE OR FEDERAL LOAN?
 YES NO

IF YES, LIST NAME OF LOAN, TYPE OF LOAN AND REASON FOR DEFAULT.

LENDING INSTITUTION OR CURRENT HOLDER OF LOAN	ACCOUNT NUMBER	BALANCE	TELEPHONE NUMBER
TOTAL: (Attach additional sheets if necessary)			

APPLICATIONS WITHOUT APPROPRIATE ATTACHMENTS WILL NOT BE PROCESSED. THE FOLLOWING INFORMATION MUST BE ATTACHED.

HAVE YOU ENCLOSED?

<input type="checkbox"/> LETTER OF SUPPORT/RECOMMENDATION FROM YOUR EMPLOYER OR COPY OF LATEST PERFORMANCE APPRAISAL <input type="checkbox"/> PROOF OF OUTSTANDING EDUCATIONAL DEBT (STATEMENTS OR PROMISSORY NOTES - MUST SHOW BEGINNING BALANCE, CURRENT BALANCE AND MONTHLY PAYMENT AMOUNT) <input type="checkbox"/> COPY OF YOUR CURRENT PROFESSIONAL LICENSE <input type="checkbox"/> COPY OF SLIDING FEE SCALE	<input type="checkbox"/> PAYER MIX PERCENT (MEDICAID, MEDICARE, PRIVATE PAY, ETC.) <input type="checkbox"/> COPY OF YOUR OFFICIAL JOB DESCRIPTION <input type="checkbox"/> LIST OF SERVICES PROVIDED BY EMPLOYER <input type="checkbox"/> EMPLOYMENT ACCEPTANCE LETTER OR COPY OF EMPLOYMENT CONTRACT <input type="checkbox"/> COPY OF YOUR DOCUMENT OF RECOGNITION (i.e. AMERICAN ASSOCIATION OF NURSE PRACTITIONERS)
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The undersigned hereby authorized the full disclosure of any information regarding the nature, amount, terms and status of this loan for the purpose of entering an agreement with the Missouri Department of Health and Senior Services for repayment of said loans.

The undersigned hereby certifies the accuracy of the information in the application and applies to enter into an agreement with the Missouri Department of Health and Senior Services for repayment of a portion of the educational loans listed above.

PLEASE PRINT FULL NAME

SIGNATURE	DATE
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