

Nurse Loan Repayment Program (NLRP) Application Instructions

Missouri Department of Health and Senior Services
Office of Rural Health and Primary Care

Contact Information for the NLRP Program
Phone #: 1-800-891-7415 or 573-751-6441
Fax #: 573-522-8146

Email: DHSS.LoanRepayment@health.mo.gov

Website: <https://health.mo.gov/living/families/primarycare/loanrepayment/>.

Note: You must complete the entire application to be considered for funding.

[Applications are accepted January 1 – March 1 of each year.](#)

Introduction

These applications instructions are for persons applying for the Nurse Loan Repayment Program (NLRP) funding. These step-by-step instructions assist in completing the application, including the methods in which are available for submitting the completed application. Contact the NLRP program with any questions and assistance with completing the application and required documentation.

The NLRP is a competitive state program that awards funding to qualifying licensed Missouri Registered and Advanced Practice Nurses for the repayment of eligible educational loans. Applicants must meet the qualifications associated with the program provisions and agree to work in a Missouri [Health Professional Shortage Area \(HPSA\)](#), upon completion of training.

Program Provisions are found in the NLRP Policies and Procedures and the [NLRP Code of State Regulations \(CSR\) PDF Document](#) (19 CSR 10-6.010).

Before You Apply:

- Carefully understand all the program provisions found in [19 CSR 10-6.010PDF Document](#).
- You must understand all the program provisions, penalties, and how contract breaches occur.
- There are *serious* financial penalties associated with breaching program contracts, which could result in paying back the entire loan amount awarded to you in addition to interest and other financial penalties.

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SECTION 1: APPLICANT'S PERSONAL INFORMATION

Fill this entire section out with requested demographic information.

1. Provide your full legal name: Last Name, First Name, and Middle Initial.
 - ✓ Please do not include nicknames or abbreviated names.
2. Provide your full Social Security Number.
3. If applicable, provide your Maiden Name or Any Other Names Used.
4. Provide your full Date of Birth: Month, Day, and Year.
5. List an Email Address that you check regularly.
 - ✓ The NLRP utilizes email as a source of communication.
6. Provide your Work Phone Number, Cellular Phone Number, and Home Phone Number.
 - ✓ Provide all applicable telephone numbers.
7. Provide the Household Income from Most Recent Income Tax Return.
 - ✓ This is also known as your Adjusted Gross Income (AGI).
 - ✓ Use your most recent Federal Income Tax Return.
 - ✓ If you reside in a parent or guardian's home or claimed as a dependent on a parent or guardian's taxes, please use your parent or guardian's recent Federal Income Tax Return.
8. Provide the Number of Dependents in your household.
 - ✓ This number should reflect the number of persons you are financially responsible for within the home.
 - ✓ If you live with a parent or guardian and do not file personal taxes, the number should reflect the number of persons the parent or guardian is financially responsible for within the home.
9. Provide your Current Address, including: Street, City, State, Zip Code, and County.
10. If applicable, identify any Languages Spoken Fluently Other Than English.
 - ✓ If you do not speak any other languages, leave this field blank.
11. Select Yes or No regarding if you are a U.S. Citizen.

DEMOGRAPHIC INFORMATION CHECK ALL THAT APPLY

Award selections will not be determined by this section.

12. Check all of the Demographic Information which apply to you. This information is used for reporting purposes only and does not affect the determination of awards. Please select the following:

- ✓ Gender: Select Male or Female.
- ✓ Ethnicity: Select Hispanic or Latino or Not Hispanic or Latino.
- ✓ Race: Select all that apply.

SECTION 2: APPLICANT'S EMPLOYMENT INFORMATION

Fill this entire section out with requested employment information.

13. Provide the Full Name of your Employer.
14. Provide the Street Address of your employer. Include the City, State, Zip Code, and County.
15. Provide the Work Telephone Number & Extension.
16. Provide a Work Email Address.
17. Provide the Facility Site Address,
- ✓ If different from the answer to number 14.
18. Provide your Supervisor's Name.
19. Provide your Supervisor's Work Telephone Number & Extension.
20. Provide your Supervisor's Work Email.
21. Under Applicant's Title, provide your employment title.
22. Under Date Employed, provide the date on which you were first employed.
23. Under This Facility Is, select all that apply:
- ✓ Private
 - ✓ Public
 - ✓ Non-Profit
 - ✓ For-Profit
24. Provide a numerical value for your Total Hours Worked Per Week.
- ✓ The total number of hours you work on a typical workweek.
25. Provide a numerical value for your Direct Patient Care Hours Per Week.

- ✓ The number of direct patient care hours out of the total number hours worked during a typical workweek should be reported in this field.
- ✓ Direct Patient Care hours include hands on, face-to-face contact with patients for the purpose of diagnosis, treatment, and monitoring.
- ✓ For the purpose of counting direct patient care hours, it is acceptable to include charting, notifying patients of test results, and telehealth clinical care.
 - ✓ The provider shall follow the Missouri Revised Statutes applicable to providing direct patient care via telehealth.
- ✓ Do not include non-direct patient care, when calculating the direct patient care hours.
 - ✓ Do not include non-clinical work that does not provide direct diagnosis, treatment, or care of the patient.

26. Select Yes or No regarding if you See Patients Regardless of Ability to Pay.

- ✓ You are attesting that you will provide services to the underserved populations, including those who are uninsured or underinsured, Medicaid and Medicare beneficiaries, and those with high deductibles.

SECTION 3: APPLICANT'S SCHOOL/RESIDENCY PROGRAM INFORMATION

27. Provide the name of your Last School Attended.

28. Provide the name of your Residency Program, if applicable.

29. Provide the Date of Completion of your education.

- ✓ Must be entered as MM/DD/YYYY.

30. Select the Degree Earned. You must select one of the following:

- ✓ Diploma in Nursing (DN)
- ✓ Associate Nursing Degree (ADN)
- ✓ Bachelor Nursing Degree (BSN)
- ✓ Master of Nursing Degree (MSN)
- ✓ Advanced Nurse Practitioner (APN)
- ✓ Doctorate Nurse (Ph.D., D.N.P., or Ed.D.)

31. Provide your Licensure Type and License Number.

- ✓ For example, RN, CRNA, FNP, etc.

32. Provide your Area of Focus, if applicable.

- ✓ Examples include: mental health, gerontology, orthopedics, etc.

33. List the Names of Any Other States in Which You are Licensed to Practice and include the associated License Number(s).

SECTION 4: ADDITIONAL INFORMATION

Information collected in this section is required for reporting purposes. Information in this section is not used for award selection.

SUBSTANCE USE DISORDER (SUD) AND TELEHEALTH QUESTIONS

34. Do You Provide SUD Services?

- ✓ Select Yes or No regarding if you provide SUD (Substance Use Disorder) services.

35. Do You Have a SUD License or Certification Issued by the State or National Crediting Agency?

- ✓ Select Yes or No documenting if you have a SUD License or Certificate.

36. Do You Have Specific Training and Credentials to Provide Evidence-Based SUD Treatment?

- ✓ Select Yes or No regarding if you have Specific Training and Credentials to Provide Evidence-Based SUD Treatment

37. Do You Provide any of the following services? Select all that apply:

- ✓ Buprenorphine
- ✓ Counseling
- ✓ Both
- ✓ Neither

38. Do You Possess a Data 2000 Waiver?

- ✓ Select Yes or No regarding if you have Possess a Data 2000 Waiver.

39. If you answered Yes to Question 38, indicate the Panel Size, which applies to your Data 2000 Waiver. Select one of the following Panel Sizes:

- ✓ DW30
- ✓ DW100
- ✓ DW275

40. Are You a Telehealth Provider?

- ✓ Select Yes or No regarding if you are a Telehealth Provider.

41. If you answered Yes to Question 40, indicate number of Approximate Hours Per Week Engaged in Telehealth.

APPLICANT'S EMPLOYMENT HISTORY IN UNDERSERVED AREAS

This information is collected for reporting purposes.

42. How Many Years You Have Provided Health Care Services in a HPSA/Rural Area?

✓ Provide a numerical value. HPSA stands for Health Professional Shortage Area.

43. How Many Additional Years You Plan to Continue Working in a HPSA/Rural Area?

✓ Provide a numerical value.

44. List All Employment Working in a Health Professional Shortage Area (HPSA/Rural Area).

For each entry:

✓ Indicate the County of the Employer.

✓ Indicate the No. of Years Served.

✓ Provide the Employer Name and your Job Title while employed there.

✓ Select either Part-Time or Full-Time.

SECTION 5: PROVIDER BILLING VERIFICATION

Obtain assistance from your facility billing department in completing Section 5.

45. Provide your National Provider (NPI) Number.

46. Provide your Medicaid Billing NPI.

✓ Nurses who bill MO Health Net Division (MHD) or MHD Managed Care plans directly for Missouri Medicaid patients, shall report their NPI.

✓ Nurse who do not bill MHD directly, provide the facility's Medicaid Billing NPI utilized to bill for Missouri Medicaid patients.

47. Do you Accept Medicaid Fee-for-Service (FFS)?

✓ If Yes: Provide the corresponding Billing NPI Number.

✓ Most likely the same billing NPI number you reported in number 46.

✓ If No or N/A: Explain briefly.

48. Do you Accept Medicaid Home State Health / or Current Replacement Plan?

✓ If Yes: Provide the corresponding Billing NPI Number.

✓ Most likely the same billing NPI number you reported in number 46.

✓ If No or N/A: Explain briefly.

- ✓ If applicable: Identify the Replacement Plan.
49. Do you Accept Medicaid Missouri Care / or Current Replacement Plan?
- ✓ If Yes: Provide the corresponding Billing NPI Number.
 - ✓ Most likely the same billing NPI number you reported in number 46.
 - ✓ If No or N/A: Explain briefly.
 - ✓ If applicable: Identify the Replacement Plan.
50. Do you Accept Medicaid United Health Care/ or Current Replacement Plan?
- ✓ If Yes: Provide the corresponding Billing NPI Number.
 - ✓ If No or N/A: Explain briefly.
 - ✓ If applicable: Identify the Replacement Plan.
51. Provide the Nurse's Medicare Provider Transactional Access Number (PTAN).
- ✓ Nurses who bill Medicare directly for Missouri Medicare patients, shall report their NPI.
 - ✓ If the nurse does not bill Medicare directly, provide the facility's Medicare Billing.
 - ✓ NPI they utilize to bill for Missouri Medicare patients.
52. Do you Accept Medicare FFS?
- ✓ If Yes: Provide the corresponding Billing NPI Number.
 - ✓ Most likely the same billing NPI number you reported in number 51.
 - ✓ If No or N/A: Explain briefly.
53. Do you Accept Medicare Advantage/ Part C Plans?
- ✓ If Yes: Provide the corresponding Billing NPI Number.
 - ✓ Most likely the same billing NPI number you reported in number 51.
 - ✓ If No or N/A: Explain briefly.
54. Are you Currently Enrolled in any other Medicare Plans?
- ✓ If Yes: Specify the Plan.

SECTION 6: EDUCATIONAL DEBT INFORMATION

55. Do you have an Existing Service Obligation, such as NHSC?
- ✓ If Yes: Provide the Date to be Completed; and
 - ✓ Indicate whether you are in Default of the Obligation. These may include service obligations associated with:

- NHSC (National Health Service Corps) Federal Scholarship or Loan Repayment Programs;
- Federal Nurse Corps Program;
- Primary Care Resource Initiative for Missouri (PRIMO) Program;
- Employment Sign-on bonuses; and
- Other Programs.

56. If applicable: Provide the Name of Program, a Contact Name, and a Contact Phone Number.

57. Have You Ever Defaulted on a State or Federal Loan?

- ✓ If Yes: List the name of the loan, type of the loan, and reason for default.

58. Only include Qualifying Debts in the table. List the following for each loan you would like considered for repayment:

- ✓ Lending Institution Name;
- ✓ Full Account Number;
- ✓ Remaining Balance; and
- ✓ Phone Number.

➤ Examples of Qualifying Educational Debt:

- ✓ Outstanding government (federal, state, or local) student loans;
- ✓ Outstanding commercial student loans;
- ✓ Consolidated or refinanced loans, so long as they are from a government (federal, state, or local) or private student loan lender and include only the qualifying educational loans of the applicant; and
- ✓ Graduate Plus Loans do qualify.

➤ Examples of Non-Qualifying Educational Debt:

- ✓ Loans for which the associated documentation cannot identify that the loan was solely applicable to undergraduate or graduate education of the applicant;
- ✓ Most loans made by private foundations;
- ✓ Fully repaid loans;
- ✓ Primary Care Loans;
- ✓ Parent Plus Loans (Graduate Plus do qualify);
- ✓ Personal lines of credit;

- ✓ Loans subject to cancellation;
- ✓ Residency loans;
- ✓ Credit card debt; and
- ✓ Loans currently in default status.

SECTION 7: REQUIRED SUPPLEMENTAL DOCUMENTATION

59. A Copy of Your Employment Contract:

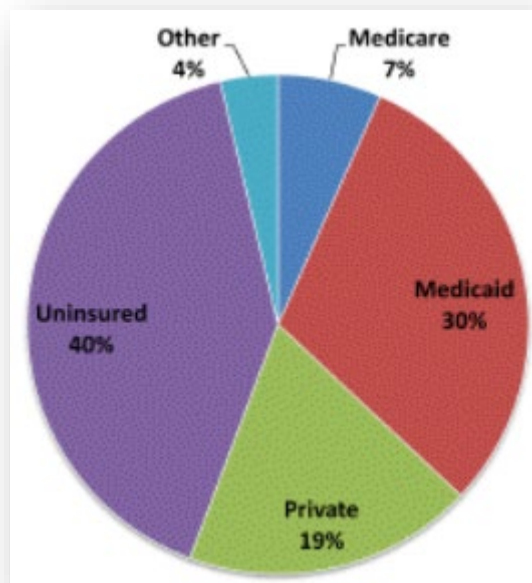
- ✓ Attach a copy of your Employment Contract for the proposed practice site for a period of no less than two years.

60. A Copy of Your Professional License:

- ✓ Attach a copy of your Professional License.

62. A Copy of the Payer Mix Report:

- ✓ Attach a copy of your facility's Payer Mix Report.
- ✓ The Payer Mix Report may be displayed as a pie chart, representing the charges billed to various types of insurance (e.g., Medicaid, Medicare, Private Insurance, Tricare, etc.). In place of a pie chart, you may submit a letter from your employer, on company letterhead, which lists these percentages.



63. A Copy of the Sliding Fee Scale:

- ✓ Attach a copy of your facility’s Sliding Fee Scale or Sliding Fee Schedule.
- ✓ Sliding Fee Scales are variable prices for services based on the patient’s ability to pay.
- ✓ Providers use this payment model to care for patients who cannot afford care, such as low-income and uninsured patients.
- ✓ The NLRP will accept your facility’s Sliding Fee Scale or Schedule.
- ✓ You may also provide your facility’s policies related to their Sliding Fee Scale or Sliding Fee Schedule.
- ✓ Sliding Fee Scale Example:

Sliding Fee Schedule (SFS) Example One

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	At or Below 100%	125%	150%	175%	200%	Above 200%
Family Size	Nominal Fee (\$5)	Charge				100% pay
		20% pay	40% pay	60% pay	80% pay	
1	0-\$12,490	\$12,491-\$15,613	\$15,614-\$18,735	\$18,736-\$21,858	\$21,859-\$24,980	\$24,981+
2	0-\$16,910	\$16,911-\$21,138	\$21,139-\$25,365	\$25,366-\$29,593	\$29,594-\$33,820	\$33,821+
3	0-\$21,330	\$21,331-\$26,663	\$26,664-\$31,995	\$31,996-\$37,328	\$37,329-\$42,660	\$42,661+
4	0-\$25,750	\$25,751-\$32,188	\$32,189-\$38,625	\$38,626-\$45,063	\$45,064-\$51,500	\$51,501+
5	0-\$30,170	\$30,171-\$37,713	\$37,714-\$45,255	\$45,256-\$52,798	\$52,799-\$60,340	\$60,341+
6	0-\$34,590	\$34,591-\$43,238	\$43,239-\$51,885	\$51,886-\$60,533	\$60,534-\$69,180	\$69,181+
7	0-\$39,010	\$39,011-\$48,763	\$48,764-\$58,515	\$58,516-\$68,268	\$68,269-\$78,020	\$78,021+
8	0-\$43,430	\$43,431-\$54,288	\$54,289-\$65,145	\$65,146-\$76,003	\$76,004-\$86,860	\$86,861+
For each additional person, add	\$4,420	\$5,525	\$6,630	\$7,735	\$8,840	\$8,840

64. A Copy of Proof of Qualifying and Outstanding Educational Debt:

- ✓ Attach copies of Proof of Qualifying and Outstanding Educational Debt.
- ✓ View examples of Qualifying and Non-Qualifying Education Debt on Number 58.
- ✓ The most accurate way to submit proof of qualifying education debt is by submitting two reports per loan; an Account Statement and a Disbursement Report.
- The Account Statement includes:
 - ✓ Verification statement is from the lender/holder; this could be evidenced by official letterhead;
 - ✓ Include the name of the borrower;
 - ✓ Contain the account number;
 - ✓ Include the date of the statement;
 - ✓ Include the current outstanding balance (principal and interest) or the current payoff balance; and
 - ✓ Include the current interest rate.
- The Disbursement Report includes:
 - ✓ Verification report is from the lender/holder; this could be evidenced by official letterhead;
 - ✓ Include the name of the borrower;
 - ✓ Contain the account number;
 - ✓ Include the type of loan;
 - ✓ Include the original loan date;
 - ✓ Include the original loan amount; and
 - ✓ Include the purpose of the loan.
- **Note:** For all federal loans, the [National Student Loan Data System \(NSLDS\)](#) may be used to verify the originating loan information.
 - ✓ If you have multiple federal loans, you only need to submit one NSLDS report.
 - ✓ The NSLDS report will contain the originating loan information for all of your federal loans.
 - ✓ You must use your Federal Student Aid ID (FSAID) to log in.
 - ✓ If necessary, you may [create a FSAID](#).

➤ **Note:** In lieu of a disbursement report, the following may be submitted for review for non-federal loans; proof can be evidenced by official letterhead of the lender:

- ✓ A promissory note;
- ✓ A disclosure statement; or
- ✓ A letter directly from the lender containing the items outlined above, under “The Disbursement Report Should”.

66. A Copy of a Letter of Support/Recommendation From Your Employer:

- ✓ Attach a copy of your Letter of Support or Recommendation or Latest Performance Appraisal or Acceptance Letter for Employment. Any will suffice.

67. Letter of Support or Recommendation from your Employer: Attach a Letter of Support or Recommendation from your Employer.

- ✓ In place of the Letter of Support or Recommendation, you may submit your Latest Performance Appraisal.
- ✓ The Letter of Support or Recommendation and/or your Latest Performance Appraisal should be dated no earlier than July 1, 2018.

68. A Copy of Your Official Job Description:

- ✓ Attach a copy of your Official Job Description.
- ✓ Your supervisor/director, or someone in the Human Resources Department may provide this to you.

69. List of Services Provided by your Employer:

- ✓ Attach a List of Services Provided by your Employer.
- ✓ This may be provided via a facility or employer pamphlet, provided said pamphlet lists all general services provided (e.g., Family Medicine, Internal Medicine, Otolaryngology).
- ✓ You may also print the list of services from your employer’s website. Do **not** submit a charge master or fee schedule.

70. A Copy of Your Most Recent Credit Report:

- ✓ Attach a copy of your Most Recent Credit Report.
- ✓ You may obtain your credit report from the Federal Trade Commission’s website: <https://www.annualcreditreport.com/index.action>.
- ✓ You may be eligible for a free credit report.

- The credit reports are used to identify:
 - ✓ Defaults on federal or non-federal payment obligations;
 - ✓ Uncollectable write-offs of federal or non-federal debts;
 - ✓ Active bankruptcies. A history of chapter 7 and/or chapter 13 bankruptcy does not disqualify you for a SLRP loan, provided the bankruptcy is listed as discharged;
 - ✓ Judgement liens from federal debt; and
 - ✓ Charge off accounts for federal debt (educational loans, FHS loans, etc.).

71. A Copy of Your Document of Recognition (i.e. American Association of Nurse Practitioners):

- ✓ Provide a copy of your document of recognition if this is applicable to you.

72. Print Your Full Name.

73. **SIGN AND DATE.**

SUBMISSION OF APPLICATION.

71. Once you have completed the application and attached the required documentation, you may submit your application. *(Submissions are accepted January 1 – March 1 of each year.)*

72. Submission Methods:

- ✓ **Electronic Submission:**

Visit: <https://health.mo.gov/living/families/primarycare/loanrepayment/>.

Select “[NLRP Electronic Application Submission](#)” at the top of the page.

Submit the completed application and required documentation.

- ✓ **Scan and Email:** DHSS.LoanRepayment@health.mo.gov.

- ✓ **Fax:** (573) 522-8146

- ✓ **Mail:**

Attn: NLRP Program
Missouri Department of Health and Senior Services
Office of Rural Health & Primary Care
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Jefferson City, MO 65102-0570