MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
HEALTH PROFESSIONAL STUDENT LOAN PROGRAMS
P.O. BOX 570, JEFFERSON CITY, MO 65102

ALL INFORMATION IS CONFIDENTIAL AND FOR PROGRAM PURPOSES ONLY.

MUST BE TYPED OR PRINTED

HEALTH PROFESSIONAL STUDENT LOAN UNIVERSAL APPLICATION

APPLICANT INFORMATION

LAST, FIRST, MIDDLE NAME	SUFFIX	SOCIAL SECURITY NUMBER	GENDER ☐ MALE ☐ FEMALE
MAIDEN NAME OR OTHER NAMES USED			BIRTHDATE

PROGRAM TYPE (SELECT ONE FROM NURSING OR PRIMARY CARE RESOURCE INITIATIVE FOR MO (PRIMO))

NURSING

- ☐ LICENSED PRACTICAL NURSING (LPN)
- ☐ DIPLOMA
- ☐ ASSOCIATE DEGREE (ADN)
- ☐ BACHELOR DEGREE (BSN)
- ☐ MASTER DEGREE (MSN)
- ☐ ADVANCED PRACTICE NURSE (APN)
- ☐ DOCTORAL (DNP)

PRIMO

- ☐ DENTAL HYGIENIST
- ☐ PRE-DENTAL
- ☐ PRE-MEDICAL
- ☐ DENTAL SCHOOL
- ☐ MEDICAL SCHOOL
- ☐ RESIDENCY PROGRAM
- ☐ PSYCHIATRIST
- ☐ PSYCHOLOGIST

TYPE OF DEGREE FOR PRIMO ONLY (PLEASE CHECK)
☐ ASSOCIATES ☐ BACHELORS ☐ MASTERS ☐ DOCTORATE

PERSONAL INFORMATION

STREET			TELEPHONE NUMBER ( )	CELL NUMBER ( )
CITY	STATE	ZIP CODE	COUNTY	ORIGINAL HOME COUNTY IN MISSOURI
E-MAIL ADDRESS		SPOUSE'S NAME		SPOUSE'S SOCIAL SECURITY NUMBER

ARE YOU A MISSOURI RESIDENT? ☐ YES ☐ NO	IF YES, FOR HOW LONG? YEARS: MONTHS:
MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ LEGALLY SEPARATED	NUMBER OF DEPENDENTS AND AGES

NAME AND ADDRESS OF PARENT OR NEAREST RELATIVE NOT LIVING IN YOUR HOME

NAME(S)	ADDRESS	
CITY, STATE, ZIP CODE	RELATIONSHIP	TELEPHONE ( )

ADDITIONAL INFORMATION FOR REPORTING PURPOSES (OPTIONAL)

RACE

- ☐ WHITE
- ☐ AFRICAN-AMERICAN
- ☐ AMERICAN INDIAN
- ☐ CHINESE
- ☐ JAPANESE
- ☐ ASIAN INDIAN
- ☐ KOREAN
- ☐ VIETNAMESE
- ☐ HAWAIIAN
- ☐ SAMOAN
- ☐ FILIPINO
- ☐ GUAMAN
- ☐ OTHER PACIFIC ISLANDER
- ☐ OTHER

HISPANIC ORIGINS? ☐ YES ☐ NO	SPEAK SPANISH? ☐ PASSABLY ☐ FLUENTLY

ENROLLMENT AND TUITION INFORMATION - This section must be completed by a financial aid officer of the educational institution.

NAME OF EDUCATIONAL FACILITY		STREET	
CITY	STATE	ZIP CODE	COUNTY
FINANCIAL AID OFFICER			FAX NUMBER ( )
E-MAIL ADDRESS	TELEPHONE NUMBER ( )		TOTAL PROGRAM COST FOR THIS ACADEMIC YEAR
STUDENT'S CURRENT PROGRAM YEAR (FRESHMAN, SOPHOMORE, ETC.)	FAMILY INCOME-FROM MOST RECENT FASFA OR TAX RETURN		FAMILY SIZE
START DATE OF THE ACADEMIC YEAR	END DATE OF THE ACADEMIC YEAR		**ANTICIPATED GRADUATION DATE (REQUIRED)**

I certify that the information in the Enrollment and Tuition Information section is complete and true to the best of my knowledge.

FINANCIAL AID OFFICER SIGNATURE	DATE

RESIDENCY TRAINING PROGRAM INFORMATION Completed by the residency program director or their designee. (Physicians only)

PROGRAM NAME		PROGRAM TYPE	
STREET		CITY	STATE
ZIP CODE	COUNTY	TELEPHONE NUMBER ( )	FAX NUMBER ( )
RESIDENT YEAR APPLICANT IS APPLYING FOR (TO/FROM)	PROGRAM DIRECTOR OR DESIGNEE NAME	EMAIL ADDRESS	

I certify that the physician referred to in this application is participating in this institution's primary care residency program and all information contained in the Residency Training Program Information section above is complete and true to the best of my knowledge.

RESIDENCY PROGRAM DIRECTOR OR DESIGNEE	DATE

SPONSORSHIPS

ARE YOU A PARTICIPANT OR HAVE PARTICIPATED IN THE FOLLOWING LOAN PROGRAMS OFFERED BY MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES OR ANY PRIMO SUPPORTED PROGRAMS?

Y N

☐ ☐ MISSOURI PROFESSIONAL AND PRACTICAL NURSING STUDENT LOAN PROGRAM

☐ ☐ PRIMARY CARE RESOURCE INITIATIVE FOR MISSOURI (PRIMO)

☐ ☐ PRIMO SUPPORTED HEALTH PROFESSIONAL STUDENT RECRUITMENT PROGRAM (E.G. AHEC)
PROGRAM NAME AND YEARS OF PARTICIPATION _____

ATTENTION: PLEASE READ BEFORE SUBMITTING APPLICATION

- ***All applications must be complete, signed, and accompanied by all required documentation. Incomplete applications will not be processed.***
- ***Proof of Missouri residency is REQUIRED. (e.g.Copy of current Missouri drivers license, state identification card, or voter's registration).***
- ***All PREVIOUS PROGRAM STUDENTS must include with their application a copy of their last semester's Grade Point Average (GPA).***
- ***Please include documentation showing any community/employer support received. (e.g., employer is paying for your tuition in return for your employment following graduation/licensure/letter of recommendation).***
- ***ACES recommendation (only for individuals who particpated in program offered through Area Health Education Centers)***
- ***Please attach any other pertinent information for which there was inadequate space for inclusion on this application.***
- ***MUST include a no more than 2-page essay (no particular format) which at a minimum, should address:***
  - ***Why are you a good candidate for this loan?***
  - ***After graduation and licensure, list your top 3 choices of where you intend to provide health services by type (i.e. hospital, clinic, etc.) and/or county and explain why you chose those locations.***
  - ***Attach a narrative and documentation explaining extenuating circumstances that prevent you from obtaining sufficient financial aid.***

APPLICANT SIGNATURE

I certify that the information contained in this application is true, complete and correct to the best of my knowledge.

I do hereby authorize the release of personal, financial and academic information related to my educational status from my past or current educational institution to the Missouri Department of Health and Senior Services or its authorized agent.

SIGNATURE	DATE

MAILING ADDRESS

OFFICE OF PRIMARY CARE & RURAL HEALTH
HEALTH PROFESSIONAL INCENTIVES PROGRAM
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
PO BOX 570, JEFFERSON CITY, MO 65102-0570

The Missouri Department of Health and Senior Services
To be the leader in promoting, protecting and partnering for health.