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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
OFFICE OF RURAL HEALTH AND PRIMARY CARE
P.O. BOX 570, JEFFERSON CITY, MO 65102

PRIMARY CARE RESOURCE INITIATIVE FOR MISSOURI (PRIMO) STUDENT LOAN APPLICATION

SECTION 1: APPLICANT'S PERSONAL INFORMATION

LAST, FIRST, MIDDLE NAME	SOCIAL SECURITY NUMBER

MAIDEN NAME OR OTHER NAMES USED	E-MAIL ADDRESS

DATE OF BIRTH	HOME TELEPHONE NUMBER	CELLULAR TELEPHONE NUMBER	WORK TELEPHONE NUMBER

STREET	CITY	STATE	ZIP CODE	COUNTY

LANGUAGES SPOKEN FLUENTLY OTHER THAN ENGLISH	U.S. CITIZEN	MISSOURI RESIDENT
	☐ Yes ☐ No	☐ Yes ☐ No If yes, how long? _____ Years _____ Months

WHAT IS YOUR ADJUSTED GROSS INCOME (AGI) ON YOUR MOST RECENT TAX RETURN?	NUMBER OF DEPENDENTS

PERMANENT ADDRESS

STREET	CITY	STATE	ZIP CODE	COUNTY

ADDRESS WHILE IN SCHOOL (IF DIFFERENT FROM PERMANENT ADDRESS)

STREET	CITY	STATE	ZIP CODE	COUNTY

DEMOGRAPHIC INFORMATION - CHECK ALL THAT APPLY (AWARD SELECTIONS WILL NOT BE DETERMINED BY THIS SECTION.)

GENDER

☐ Male ☐ Female

ETHNICITY

☐ Hispanic or Latino ☐ Not Hispanic or Latino

RACE

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White/Caucasian
☐ Other: _____

SECTION 2: PROGRAM TYPE/DEGREE FOR WHICH YOU ARE CURRENTLY ENROLLED

☐ Dental Hygienist
☐ Pre-Dental
☐ Pre-Medical
☐ Dental School
☐ Medical School
☐ Residency Program
☐ Psychiatrist

TYPE OF DEGREE

☐ Associate
☐ Bachelor's
☐ Master's
☐ Doctoral Degree

MISSOURI RESIDENT FOR 1 YEAR OR LESS?	IF YES, WAS THIS ONLY TO ATTEND YOUR CURRENT SCHOOL?
☐ Yes ☐ No	☐ Yes ☐ No

SECTION 3: SPONSORSHIPS

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

YES	NO	
☐	☐	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(s) name and years of participation _____

_____

SECTION 4: DOCUMENTATION REQUIREMENTS

You must include the following documentation for your application to be complete:

- ☐ Proof of Missouri residency (e.g., a copy of your current Missouri driver's license, Missouri state-issued identification card, or Missouri voter identification card).
- ☐ A copy of your financial aid award notice from your school.
- ☐ A copy of your current FAFSA Student Aid Report or an institutional Student Information Record (ISIR).
- ☐ A copy of your most recent tax return reporting your adjusted gross income (AGI).
- ☐ Documentation of Community/Employer Support (i.e. Letter of recommendation).
- ☐ ACES Recommendation **Only for those who participated in ACES Program through Area Health Education Centers.*
- ☐ Attach a Narrative/Essay:
  - No more than 2 pages; in no particular format.
  - Explain why you are a good candidate for this loan.
  - List your top 3 choices of where you intend to provide health care services, including the county and facility type (hospital, clinic, etc.). Explain why these are your top choices.
  - Explain your financial situation related to your need for a Primary Care Resource Initiative for Missouri student loan.

SECTION 5: CONFLICTING SERVICE OBLIGATION

Applicants will not be selected if they have another existing/remaining service obligation as a health professional, or any other service obligation, to the Federal government (e.g., an active duty military obligation, NHSC Scholarship Program obligation, a NURSE Corps Scholarship or Loan Repayment Program obligation).

DO YOU HAVE AN EXISTING SERVICE OBLIGATION?	IF YES, DATE TO BE COMPLETED
☐ Yes ☐ No	

IF YOU ARE UNDER ANY SERVICE OBLIGATION, PLEASE DESCRIBE THE OBLIGATION (INCLUDING THE NAME AND TYPE OF PROGRAM)

SECTION 6: ATTESTATION STATEMENT

I attest that, upon graduation, I will provide primary care services within my scope of practice in a Missouri DHSS-defined Health Professional Shortage Area (HPSA) as part of my loan forgiveness obligation in order to earn forgiveness on the funds awarded to me.

☐ Yes ☐ No

APPLICANT SIGNATURE

I certify that that 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 institutional to the Missouri Department of Health and Senior Services or its authorized agent.

APPLICANT SIGNATURE	DATE

SECTION 7: ENROLLMENT AND TUITION INFORMATION - THIS SECTION MUST BE COMPLETED BY A FINANCIAL AIDE OFFICER OF THE EDUCATIONAL INSTITUTION.

NAME OF EDUCATIONAL INSTITUTION

STREET	CITY	STATE	ZIP CODE	COUNTY

FINANCIAL AID OFFICER NAME AND TITLE (PRINTED)	FINANCIAL AIDE OFFICER E-MAIL ADDRESS
FINANCIAL AIDE OFFICER TELEPHONE NUMBER	**FINANCIAL AID OFFICER FAX NUMBER**
STUDENT'S CURRENT PROGRAM YEAR (I.E., FRESHMAN, SOPHOMORE, ETC.)	TOTAL PROGRAM COST FOR THIS ACADEMIC YEAR

START DATE OF THE ACADEMIC YEAR	END DATE OF THE ACADEMIC YEAR	ANTICIPATED GRADUATION DATE

STUDENT ENROLLED	IS THE STUDENT IN GOOD ACADEMIC STANDING?
☐ Full-Time ☐ Part-Time	☐ Yes ☐ No ☐ N/A First Year Student

FINANCIAL AIDE OFFICER SIGNATURE

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

FINANCIAL AIDE OFFICER SIGNATURE	DATE

SECTION 8: RESIDENCY TRAINING PROGRAM INFORMATION - THIS SECTION MUST BE 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.

PROGRAM DIRECTOR OR DESIGNEE SIGNATURE	DATE