Northeast Delta Dental Tri-State Loan Payment Reimbursement Program Application -- Fall 2022 Cycle

Timeline: This application is due 12/23/22.

Applicants should submit completed applications to loanprogram@bistatepca.org by 12/23/22.

Questions? Please email loanprogram@bistatepca.org or call 603-228-2830 ext. 143.

Program Elements:

This Tri-State Loan Payment Reimbursement Program (the **Program**), funded by Northeast Delta Dental, promotes increased access to oral health services by offering reimbursement for educational loan payments to eligible dentists throughout northern New England (ME, NH, and VT). The first application cycle is in the Fall of 2022. There will be subsequent application cycles annually in 2023-2025. Awards will be made each year, with applicants eligible to receive funding for up to three years. Applicants must annually verify they meet program criteria for funding beyond the first award year by completing and signing the Reimbursement Certificate attached below.

Reimbursements are available up to $50,000/year. Please note that these payments are considered taxable income. Decisions regarding eligibility and funding of awards are determined by Northeast Delta Dental in their sole discretion. Their decisions are final with respect to all matters related to the Program.

Eligibility Criteria:

To be eligible for the Program, dentists, whether in a for-profit or not-for-profit clinic, may be a U.S. or Non-U.S. Citizens but must:

1. Have been educated in a U.S. or Foreign Dental Schools. Have verifiable education debt from a U.S. Education Lending Program.
2. Not have a Concurrent Service Obligation.
3. Be licensed or actively seeking licensure to practice and working as a clinician in ME, NH, or VT.
4. Work a minimum of 20 hours/week in a dental practice in northern New England. This dental practice can be for profit or not for profit.
5. Be enrolled as a Medicaid provider and actively participating in the Medicaid program in the applicable state.
6. Agree to abide by the terms and conditions of the Program, as they exist on the date hereof and as they may be changed from time to time.
7. Have not been sanctioned, disciplined, reprimanded, suspended by, or expelled from participation in Medicare, Medicaid, SCHIP, or other federal or state health care programs or otherwise sanctioned by the Office of the Inspector General in the past five (5) years.

Additionally, applicants may be awarded preferential consideration for the following:

a. Serving in a practice that is located in an underserved geographic area or with an underserved population and/or areas with demonstrated workforce shortages or other access to care considerations. This is regardless of rural or urban zip code.
b. Engaging in full time practice (which can be in multiple locations).
c. Living in ME, NH, or VT as a resident.
d. Committing to treating a high number of adult and pediatric Medicaid patients (this can be both for the individual and within the entire practice).
e. Fulfilling key state priorities as identified below.

Answering yes to any of the questions below requires that an **explanation be attached** to the application.

- Do you have a judgement lien against your property for a debt to the United States? Yes_ No_
- Do you have any federal debt written off as not collectible or any federal service or payment obligation waived? Yes _ No _
- Has your dental license been denied, revoked, suspended, or made subject to probation or any conditions, restrictions, or limitations in any state for any reason in any state?Yes _ No _
  If yes, when? _____
  Reason for suspension/revocation:_____
- Are any professional disciplinary actions against you pending in any state? Yes _ No _
  If yes, date of disciplinary action (month/year): _____/_____
  Reason: _____
- Have you ever been convicted or pled guilty to a felony as so defined under either Federal or State laws and which has not been annulled Yes _ No _
- Are you delinquent in childcare payments in any State? Yes _ No _
  If yes, please explain: _____

Have your privileges to practice (whether in an insurer network, in the military, or in any other setting) been suspended, lost, or limited due to disciplinary action?

Has your dental license been denied, revoked, suspended, or made subject to probation or any conditions, restrictions, or limitations in any state for any reason in

State-Specific Priorities for Consideration by Award Committee (sorted alphabetically)		
Maine **8/1/2022 Discussion**	**New Hampshire** **8/9/2022 Discussion**	**Vermont** **8/10/2022 Discussion**
- Adult Medicaid Panel - General Dentist - Patients with Special Needs - Serves Intellectually Disabled Population - Services Under Sedation	- Adult Medicaid Panel - General Dentists - Manchester (urban) - Oral Surgeons North and Southwest - Patients with Special Needs / Disabilities	- Addressing Maldistribution of Pediatric Dentists - Adult Medicaid Panel - Dentists who Serve as Preceptors for Students/Residents - Endodontics - General Dentists - Oral Surgeons - Patients with Special Needs Especially in South - Prosthodontist

APPLICATION FORM

Legal Name	**Practice Name**	
Address	**Email Address**	**Mobile Phone**
Amount Requested	**$**	

The Applicant certifies and agrees to the following by **initialing** next to each one:

_____ The dollar amount for which forgiveness is requested was used to pay costs that are eligible for forgiveness (verifiable education debt from a US education lending program).

_____ The Applicant meets and agrees to all of the Eligibility Criteria in this Application.

Loan Information:

Outstanding loan debt amount	*Lender*

*Attach copies of all outstanding dental educational loan balances from the month previous to, or month of, this application. Copies of education loan balances not received will not be considered. Please be especially diligent when completing this section, filling in each loan then the total of the loans. Those marked "Attached" will be deemed incomplete causing delay.

Lender Name	Account #	Original Amt of Loan	Current Balance Due	Balance Due Date	Monthly Payment
	TOTAL				

Application Questions (As needed Please answer on a separate sheet of paper with corresponding question and answer numbers):

1. Why are you seeking loan forgiveness through this program?
2. Do you qualify for other state/federal loan programs? _____YES_____NO. If yes, please explain why you are not participating in these other programs and instead seeking funding through this program.

3. Please describe the community where you are (or will be) practicing dentistry. Specifically, please describe how the community is underserved or the populations you are treating are underserved.
4. Are you a General Dentist or a Specialist (circle one)? Please describe if a Specialist.
5. There is a table with state-specific priorities listed on page 1 of this application, please describe how you meet the priorities (if applicable).
6. Are you working in multiple practices? _____YES_____NO. If yes, please describe:
7. What is the anticipated number of Medicaid patients you will treat in the next year? _____.
8. Do you want to be considered for annual funding (up to a total of three years) if you continue to meet program qualifications and funds are available? _____YES_____NO.
9. How many hours do you work each week? _____

The Applicant's eligibility will be evaluated in accordance with the Program criteria. The Applicant certifies that this Application is true, correct and complete.

_____ _____

Applicant Signature Date

_____

Print Name

REIMBURSEMENT CERTIFICATE
(to be completed and submitted with respect to annual funding)

The Applicant certifies to all of the following by initialing next to each one.

_____ Attached loan statement demonstrating the amounts the Applicant paid during the period beginning _____ and ending _____ (the **Period**).

_____ The dollar amount I paid during the Period is $_____. This amount was used to pay costs that are eligible for forgiveness (verifiable education debt from a US education lending program).

_____ I continue to meet the Eligibility Criteria and hereby certify all of the following with respect to the Period:

1. I have not had a Concurrent Service Obligation.
2. I was licensed or actively seeking licensure to practice and working as a clinician in ME, NH, or VT.
3. I have worked a minimum of 20 hours/week in a dental practice in in ME, NH, or VT.
4. I am enrolled as a Medicaid provider and actively participating in the Medicaid program in the applicable state.

The undersigned certifies that this Reimbursement Certificate is true, correct and complete.

_____ _____

Applicant Signature Date

_____

Print Name