Practice Site Application
GPLRP Loan Repayment Program

I. Practice Site Information

Please type or print

Name of Practice Site: ______________________________

Address: ______________________________

City: ________________ State: ____________ Zip Code: ____________

Practice Phone: ____________ Practice Ownership: ________________

Site Description: ______________________________

(e.g., Hospital Clinic, Community Health Center, 330 Clinic, Rural Health Clinic, County owned Clinic, etc.)

Practice Type: ◯ Public ◯ Private Non-Profit* ◯ Private For-Profit

***Attach IRS non-profit documentation, if applicable**

County: ______________ Referral Hospital: ________________

Hospital Address: ______________________________

City: ________________ State: ____________ Zip Code: ____________

Hospital Ownership:______________________________

Other towns in practice service area: ______________________________

Name of Provider whose application this Site Application supports:

Name: ______________________________

Address: ______________________________

City: ________________ State: ____________ Zip Code: ____________

Specialty: ______________________________

II. Practice Site Assurances

Practice Site Official must initial all requirements with which practice entity tends to comply

Salary:

_______ Site shall compensate providers at salaries that are competitive with other health professionals in the area.

_______ Site shall not use Loan Repayment Program award as a means to reduce provider salaries or offset provider salaries.

Accessibility:

_______ Providers will accept assignments for Medicare and Medicaid patients.

_______ Site must charge for professional services at the usual and customary prevailing rates.

_______ Site uses sliding discount fee schedule that assures no financial barriers to care for individuals with limited incomes.

_______ Site must provide services at no charge or a nominal charge for those with incomes at or below 100% of the HHS Poverty Guidelines, .

_______ Site must provide a schedule of discounts For those between 100% and 200% of the HHS Poverty Guidelines, which should reflect a nominal charge covered by a third party (either public or private).

_______ Site will conspicuously post a statement of nondiscrimination based on ability to pay.

_______ Site has a nondiscrimination policy that prohibits discrimination based on race, creed, disability or religion.

Comprehensive System of Care:

_______ Providers shall practice in ambulatory care settings that assure the availability of services, including lab and x-ray, pharmacy, after-hours and referral arrangements for services not available on site.

Provider Employment Contract:

_______ Provider shall practice only in the approved site targeted by the Georgia Physician Loan Repayment Program and named in the provider application as approved by the Georgia Board for Physician Workforce for a period of at least two years.

_______ All providers will have contracts or employment agreements that stipulate providers perform full-time clinical practice defined as a minimum of forty hours per week and a minimum of 45 weeks per year.

_______ Site shall communicate with the Georgia Board for Physician Workforce staff regarding the status of providers, including resignations, terminations and extended leave of absence.

_______ Site shall document all circumstances surrounding resignations and terminations.

_______ Site must immediately inform the Georgia Board for Physician Workforce if it is no longer willing or able to comply with any of the above conditions.

III. Practice Site Certification

To be completed by official authorized to warrant the foregoing on behalf of the practice entity

I certify that the information provided in this application is true and correct as of the date set forth opposite my signature. I also understand that any intentional or negligent misrepresentation(s) of the information contained may result in the forfeiture of our entity's eligibility to participate in the State Loan Repayment Program

____

Signature and Title of practice entity official

____

Name of practice entity

Official Notary:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgements, ____________________________ (practice official), to me well known to be the person described herein and who executed the foregoing instrument, and he/she acknowledges before me that he/she executed the same freely and voluntarily for the purpose therein expressed.

WITNESS my hand and official seal at the City of _____________ , County of _________________ and state of ______________,

This ______________day of ________________, 20___.

____

Notary Public (Full legal signature)

Affix Seal

My commission expires:___________

PLEASE RETURN COMPLETED FORM TO:

GBPW c\o GPLR Program

2 Peachtree Street, N.W., 36th Floor

Atlanta, Georgia 30303

Questions? Call **404-232-7972**

E-mail: gbpw@dch.ga.gov