



Georgia Board for Physician Workforce

2 Peachtree Street, NW, 36th Floor, Atlanta, Georgia 30303-3141

Phone: 404-232-7972 Fax: 404-656-2596

October 10, 2013

Dear Applicant:

Enclosed are application materials for the Georgia Board for Physician Workforce Georgia Dentist Assistance Program. This program is a two-year initiative of the Georgia Board for Physician Workforce (GBPW) and the Georgia Department of Community Health, State Office of Rural Health (SORH). The program offers loan repayment for both full-time and part-time employment at a Federally Qualified Health Center (FQHC) in Georgia. The purpose of this program is to grant service cancelable loans of up to \$50,000 to dentists to repay outstanding dental education debt in return for dental practice in a FQHC. Program specifics are outlined in the attached Applicant Information Bulletin. Also attached are an application for the program and other documentation required to be submitted along with the application.

Please complete the attached Application and return it as soon as possible. Your application will not be considered complete until all application materials have been received. Applications will be presented to the Georgia Board for Physician Workforce for approval at its January 2014 meeting. The completed application must be received by December 1, 2013.

Feel free to contact me at 404.232-7972 or gbpw@dch.ga.gov.

Sincerely,

Cherri Tucker

Cherri Tucker
Executive Director

Georgia Board for Physician Workforce

Georgia Federally Qualified Health Center (FQHC) **Dentist Assistance Program**



Applicant Information Bulletin

This document describes the Georgia FQHC Dentist Assistance Program. Program participants will be bound by contract to adhere to the provisions outlined in this document.

Keep this Bulletin for future reference. It explains in detail the obligations of program participants.

GEORGIA BOARD FOR PHYSICIAN WORKFORCE

Georgia Federally Qualified Health Center (FQHC) Dentist Assistance Program

PURPOSE OF THE PROGRAM

The purpose of the Georgia FQHC Dentist Assistance Program is to increase access to dental care throughout the state, particularly to underserved populations, by providing loan repayment to dentists working in eligible Federally Qualified Health Centers (FQHCs) in Georgia.

PROGRAM REQUIREMENTS AND CONTRACTUAL OBLIGATIONS

The Georgia FQHC Dentist Assistance Program is a two-year initiative of the Georgia Board for Physician Workforce (GBPW) and Georgia Department of Community Health, State Office of Rural Health (SORH) to provide loan repayment to dentists in exchange for working at one or more FQHCs in Georgia. The program will award up to \$25,000 per year for a two-year maximum of \$50,000.

The program offers loan repayment for both full-time and part-time employment at an FQHC, as defined below:

Full-Time Service: Full-time service is defined as a minimum of 40 clinical hours per week for a minimum of 45 weeks per year and is eligible for up to \$25,000 per year of service.

Part-Time Service: Part-time service is defined as a minimum of 20 clinical hours per week for a minimum of 45 weeks per year and is eligible for up to \$10,000 per year of service.

Priority is extended to full-time applications. Review of part-time applications is dependent upon the availability of funds after all full-time applications have been reviewed and awarded.

Practice time for services provided at locations other than approved FQHCs (i.e., non-program service) is not credited toward the 40-hour full-time or 20-hour part-time service requirement.

All recipients are required to sign a contract with the Georgia Board for Physician Workforce agreeing to the terms and conditions upon which awards are granted. This contract establishes the amount of the award, the location of service repayment, the contract date, the dates of obligated service, as well as the terms and conditions of program participation, and the conditions of default and cash repayment.

Loan repayment awards are based upon the amount of funds provided to GBPW by SORH.

ELIGIBLE STUDENT LOANS

Student loans incurred for tuition, fees, and other expenses associated with completion of a dental degree are eligible for repayment under the Georgia FQHC Dentist Assistance Program. Student loan debt incurred to complete other academic degrees is not eligible for repayment under the program.

APPLICATION REQUIREMENTS

Eligible applicants must:

- 1) Be a U.S. citizen;
- 2) Hold the degree of Doctor of Dental Surgery (D.D.S) or Doctor of Dental Medicine (D.M.D.) from a dental school in the United States accredited by the American Dental Association's Commission on Dental Accreditation;
- 3) Hold a current unrestricted dental licensure by the Georgia Board of Dentistry;
- 4) Hold a Georgia Medicaid provider number and provide dental services to Medicaid patients in Georgia;
- 5) Be in good standing with regard to meeting the contractual requirements of existing student loans;
- 6) Establish and maintain residence in the community in which you practice;
- 7) Submit an application to participate in the Georgia FQHC Dentist Assistance Program no later than December 1st (Submitting an application does not guarantee selection);
- 8) Disclose all outstanding dental education loan debt – original promissory note;
- 9) Agree to adhere to all federal guidelines related to providing dental services in FQHCs;
- 10) Submit executed copy of employment contract;
- 11) Contractually agree to practice either full-time (minimum of 40 clinical hours per week) or part-time (minimum of 20 hours per week) at one or more FQHCs in Georgia; and
- 12) Have completely satisfied any other obligation for health professional service owed under any agreement with the Federal Government, State Government, or other entity prior to the beginning of service under this program.
- 13) Submit Affidavit of Lawful Presence and a Secure and Verifiable document (Appendix A)

APPLICATION PROCESS, REPORTING, AND RENEWAL

Completed applications must be submitted no later than December 1st for consideration during the fiscal year.

Application forms are available from the Georgia Board for Physician Workforce office at 2 Peachtree Street, NW, 36th Floor, Atlanta, Georgia 30303, telephone (404) 232-7972 or on the GBPW website at www.GBPW.Georgia.gov.

All information requested in the application must be complete prior to Board consideration.

Further information is available by contacting the Board offices. The Board may request that the applicant make a personal appearance before the Board, although this is not typically the case.

Notice of award will be mailed to all candidates after a candidate has been approved by the Board. Upon receipt of acceptance of the award, the Board will issue a Georgia FQHC Dentist Assistance Program contract. Payment of the award is made once the contract is fully executed. Recipients will receive 75% of total award amount upon contract execution and the remaining 25% upon completion of the service requirement.

Funding for Georgia FQHC Dentist Assistance Program loan repayment awards are available for state fiscal year 2014 and 2015. Applicants receiving an award during FY2014 have the option of signing a two-year contract or a one-year contract with the option to renew for an additional year in FY2015 (up to \$50,000 maximum). Applicants receiving an award during FY2015 only are limited to one year of loan repayment (up to \$25,000 maximum).

Each recipient is required to complete and submit an annual status report to the Board. Renewal applications are available from the GBPW office and are due no later than October 31, 2014.

Notice of award will be mailed to each recipient upon approval for renewal by the Board. Upon receipt of acceptance of the renewal award, the Board will issue a new Georgia FQHC Dentist Assistance Program contract for an additional one year. Payment of the award is made upon full execution of the contract. Recipients will receive 75% of total award amount upon contract execution and the remaining 25% upon completion of the service requirement.

CONTRACT DEFAULT

The contract includes a penalty of double the principal award amount received for:

- 1) Failure to begin or complete the full twelve-month service commitment in the location named in the contract;
- 2) Failure to meet the 40 clinical hours per full-time week or 20 clinical hours per part-time week practice commitment, or
- 3) Failure to provide Board staff with access to records and other information necessary to document compliance with contract terms.

The cost of attorney fees and other expenses associated with collection are assessed in addition to the double default penalty.

FURTHER INFORMATION AND ASSISTANCE

Please contact the Georgia Board for Physician Workforce if you have any questions or need additional information.

Georgia Board for Physician Workforce
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3141
404-232-7972-Office
404-656-2596-Fax
E-mail: gbpw@dch.ga.gov
Website: www.gbpw.georgia.gov

Georgia Board for Physician Workforce
Georgia FQHC Dentist Assistance Program

Application

SECTION I - PERSONAL DATA

Please type or print with black or blue ink.

Applicant's Full Legal Name: _____

Address: _____
(Street Address Only -- No P.O. Boxes)

City: _____ State: _____ Zip Code: _____

Work Phone: _____ Home Phone: _____

Social Security #: _____ Birth Date: _____

Birth Place: _____ Are you a United States Citizen? ☐ Yes ☐ No

Language other than English: _____ ☐ Speak ☐ Write ☐ Read

SECTION II - DENTAL EDUCATION

Dental School: _____ Graduation Date: _____

City: _____ State: _____

GA Dental License Number: _____

SECTION III - PRACTICE SITE

Applicant agrees to provide **full-time** / **part-time** (circle one) general dentistry services for one year at:

Practice Site Name: _____

Address: _____

City: _____ County: _____ Zip Code: _____

Telephone: _____ Fax: _____

SECTION III – PRACTICE SITE (Continued)

Federal Employer Identification Number for practice: _____
OR Attach 501 C-3 (IRS non-profit documentation), if applicable.

Beginning Date of Practice: _____ (This will not be the date service will commence)

Number of clinical hours per week at this practice location: _____

Are you receiving loan repayment through this employer? _____ Yes _____ No

Include a copy of the contract between yourself and your practice/employer.

SECTION IV – DENTAL EDUCATION DEBT

Estimate of total outstanding dental education debt from all loan holders: \$ _____

Request submission of the attached *Lender Disclosure Form* from each loan holder.

Attach a current loan statement for each loan listed. Loan statements must contain Applicants name, account number, the principle and pay-off balance.

1. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: \$ _____

2. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: \$ _____

3. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: \$ _____

4. Loan Holder: _____

Loan Holder Address: _____

City: _____ State: _____ Zip Code: _____

Account Number: _____ Loan Balance: \$ _____

SECTION V - CERTIFICATION

I certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I hereby consent fully to verification of any and all information included in this application. I understand that any willfully false representation of information is sufficient cause for rejection of this application. I have fully disclosed all outstanding dental education debt and am not currently in default of any service or loan obligation.

Applicant Signature (Full Legal Name)

Date

Official Notary:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments, _____ (applicant's name), 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:

Mail your completed application to:

Georgia Board for Physician Workforce
Georgia FQHC Dentist Assistance Program
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3141

Direct questions to Staff at 404/232-7972 or gbpw@dch.ga.gov
www.gbpw.georgia.gov

GEORGIA BOARD FOR PHYSICIAN WORKFORCE

**AUTHORIZATION and RELEASE FORM
for the Georgia FQHC Dentist Assistance Program**

FULL LEGAL NAME OF APPLICANT: _____

TO WHOM IT MAY CONCERN:

I, _____, have filed an application with the Georgia Board for Physician Workforce Georgia FQHC
Applicant's Full Legal Name

Dentist Assistance Program to repay the cost of my tuition and other dental education expenses incurred while obtaining my dental education and training. I recognize that it is the responsibility of the members of said Board to determine that only those qualified persons of high character and recognized ability, who have entered into a contract with an eligible practice entity, submitted all required application forms and documentation and closed all dental education debts and obligations, are eligible for loan repayment. To this end, and for the entire contract period, I hereby authorize and request any college or school official, lending institution or organization and any other person or official of any firm, association or corporation to answer any inquires, questions, interrogatories, or furnish any information whatsoever concerning the undersigned on forms or requests which may be submitted to them by the Georgia Board for Physician Workforce or its authorized representative, and to appear before said Board, or its authorized representative, and to give full and complete testimony concerning the undersigned, including any information furnished by the undersigned. I hereby relinquish any and all rights to said reports, evaluations, consultations, letters of recommendation or any other information or material incident in any way to authorized reviews by Georgia Board for Physician Workforce Board, or its authorized representative, and fully understand that I shall not be entitled to have disclosed to me the contents of any of the foregoing.

I hereby release and exonerate all such persons authorized by the Georgia Board for Physician Workforce, who shall comply in good faith with this authorization and request from any and all liability of every nature and kind whatsoever growing out of or in any way pertaining to the furnishing of such information or inspection of any document, record and other information or any investigation by said Georgia Board for Physician Workforce.

Further, the undersigned hereby waives absolutely any right which he/she may have under the laws of Georgia governing confidential or privileged communications, as codified in Sections 38-418, 38-419.1 of the Georgia Code Annotated, as now or hereafter amended.

IN WITNESS WHEREOF, I have set my hand and seal this _____ day of _____, 20__.

Applicant's Full Legal Signature

STATE OF _____ COUNTY OF _____

OFFICIAL NOTARY:

I HEREBY CERTIFY that on this day, personally appeared before me, an officer duly authorized to administer oaths and take acknowledgments,

Applicant's Full Legal Name

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 City of _____, County of _____

and State of _____, this _____ day of _____, 20__.

Legal Signature, Notary Public

(Place Seal Imprint Here)

My Commission Expires: _____

**Georgia FQHC Dentist Assistance Program
Outstanding Dental Education Loan Debt Information
-----LENDER DISCLOSURE-----**

Applicant: This form must be sent to each lending institution or agency for which you are seeking loan repayment. The lending institution should forward the completed form to our office.

Lender: If the named individual's application is approved, the information requested below will be used to arrange third party pre-payment of a portion or all of the applicant's debt.

Applicant's Name as it Appears on Loan: _____

Original Lending Institution, Federal or State Program, Please Provide:

Full Name of Institution or Program	Contact Person	Telephone Number
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Street Address	City	State	Zip
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Loan ID Number	\$	Original Loan Amount	Date of Original Loan
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Grace Period/Forbearance Dates	\$	Current Balance	Date of Balance
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Interest Rate _____ %		Simple or Compound	
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If interest rate is variable, explain terms: _____

Purpose of loan as indicated on original loan application: _____

Certification by Applicant Borrower:

I hereby authorize the government or financial institution named above to release this information to the Georgia Board for Physician Workforce for the purpose of repayment of outstanding dental education debt through the Georgia FQHC Dentist Assistance Program. I also certify the accuracy of the enclosed information and apply to enter into an agreement with the GEORGIA BOARD FOR PHYSICIAN WORKFORCE – GEORGIA FQHC DENTIST ASSISTANCE PROGRAM of all or the appropriate portion of the education loan listed above, incurred solely for the cost of dental education, including reasonable living expense at a school of dentistry.

Full Legal Signature: _____ **Date:** _____

Certification by Authorized Agency of Lending Institution:

The undersigned states that, to the best of his or her knowledge, the loan identified above is a bona fide, legally enforceable, commercial, state or government educational loan, made for the purpose of meeting the borrower's costs of attaining the degree of Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.).

Print/Type Name of Authorized Agent	Title
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Official Signature: _____

Lender Organization's Federal Employer Identification Number: _____

Return to: Georgia Board for Physician Workforce, 2 Peachtree St., NW, 36th Floor, Atlanta, Georgia 30303-3141

O.C.G.A. § 50-36-1(e)(1)(B) Affidavit

By executing this affidavit under oath, as an applicant for a **Georgia FQHC Dentist Assistance Program grant**, as referenced in O.C.G.A. § 50-36-1(4)(A), from the **Georgia Board for Physician Workforce, State of Georgia**, the undersigned applicant verifies one of the following with respect to my application for a public benefit:

- 1) _____ I am a United States citizen.
- 2) _____ I am a legal permanent resident of the United States.
- 3) _____ I am a qualified alien or non-immigrant under the Federal Immigration and Nationality Act with an alien number issued by the Department of Homeland Security or other federal immigration agency.

My alien number issued by the Department of Homeland Security or other federal immigration agency is: _____.

The undersigned applicant also hereby verifies that he or she is 18 years of age or older, is legally authorized to sign on behalf of the entity represented, and has provided at least one secure and verifiable document, as required by O.C.G.A. § 50-36-1(e)(1), with this affidavit.

The secure and verifiable document provided with this affidavit can best be classified as:

_____.

In making the above representation under oath, I understand that any person who knowingly and willfully makes a false, fictitious, or fraudulent statement or representation in an affidavit shall be guilty of a violation of O.C.G.A. § 16-10-20, and face criminal penalties as allowed by such criminal statute.

Executed in _____ (city), _____ (state).

Signature of Applicant

Printed Name of Applicant

SUBSCRIBED AND SWORN
BEFORE ME ON THIS THE
___ DAY OF _____, 20___

NOTARY PUBLIC
My Commission Expires:

Secure and Verifiable Documents Under O.C.G.A. § 50-36-2
Issued August 1, 2011 by the Office of the Attorney General, Georgia

The Illegal Immigration Reform and Enforcement Act of 2011 (“IIREA”) provides that “[n]ot later than August 1, 2011, the Attorney General shall provide and make public on the Department of Law’s website a list of acceptable secure and verifiable documents. The list shall be reviewed and updated annually by the Attorney General.” O.C.G.A. § 50-36-2(f). The Attorney General may modify this list on a more frequent basis, if necessary.

The following list of secure and verifiable documents, published under the authority of O.C.G. A. § 50-36-2, contains documents that are verifiable for identification purposes, and documents on this may not necessarily be indicative of residency or immigration status.

- A United States passport or passport card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States military identification card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A driver’s license issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An identification card issued by one of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Commonwealth of the Northern Marianas Islands, the United States Virgin Island, American Samoa, or the Swain Islands, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A tribal identification card of a federally recognized Native American tribe, provided that it contains a photograph of the bearer or lists sufficient identifying information regarding the bearer, such as name, date of birth, gender, height, eye color, and address to enable the identification of the bearer. A listing of federally recognized Native American tribes may be found at: <http://www.bia.gov/WhoWeAre/BIA/OIS/TribalGovernmentServices/TribalDirectory/ind/ex.htm> [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A United States Permanent Resident Card or Alien Registration Receipt Card [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- An Employment Authorization Document that contains a photograph of the bearer [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A passport issued by a foreign government [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Merchant Mariner Document or Merchant Mariner Credential issued by the United States Coast Guard [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]

- A Free and Secure Trade (FAST) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A NEXUS card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A Secure Electronic Network for Travelers Rapid Inspection (SENTRI) card [O.C.G.A. § 50-36-2(b)(3); 22 CFR § 41.2]
- A driver's license issued by a Canadian government authority [O.C.G.A. § 50-36-2(b)(3); 8 CFR § 274a.2]
- A Certificate of Citizenship issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-560 or Form N-561) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- A Certificate of Naturalization issued by the United States Department of Citizenship and Immigration Services (USCIS) (Form N-550 or Form N-570) [O.C.G.A. § 50-36-2(b)(3); 6 CFR § 37.11]
- In addition to the documents listed herein, if, in administering a public benefit or program, an agency is required by federal law to accept a document or other form of identification for proof of or documentation of identity, that document or other form of identification will be deemed a secure and verifiable document solely for that particular program or administration of that particular public benefit. [O.C.G.A. § 50-36-2(c)]