Commonwealth Healthcare Corporation
Commonwealth of the Northern Mariana Islands
1178 Hinemlu St. Garapan, Saipan, MP 96950

CNMI CHCC State Loan Repayment Program
Health Professional Application

General Information

The Commonwealth Healthcare Corporation (CHCC) is pleased to announce the Commonwealth of the Northern Mariana Islands State Loan Repayment Program (CNMI CHCC-SLRP), a grant funded program. The State Loan Repayment Program will offer primary care and behavioral health care providers who work at CHCC, an organization designated as a Health Professional Shortage Areas (HPSAs) in the CNMI, assistance in repayment of educational loan debt.

Who's Eligible? Dentists; pharmacists; physician assistants; registered nurses; licensed clinical social workers; and licensed alcohol and substance abuse counselors. Applicants must be United States citizens or U.S. Nationals, have no outstanding contractual obligation for health professional services to the Federal Government, State or other entity, no judgment lien against their property for a debt to the U.S. government and not be excluded, debarred, suspended, or disqualified by a federal agency. Initial eligibility will be evaluated through background and credit checks. Awarded recipients will be selected by a subcommittee of the CHCC SLRP Advisory Committee.

All selected will be obligated to commit to 2 years of full-time service or 4 years of part-time service at CNMI CHCC-SLRP sites. CNMI CHCC-SLRP sites are located within the CHCC organizational structure and provide health services in primary care health professional shortage areas (HPSAs) of discipline. A list of the HPSA locations can be viewed at http://hpsafind.hrsa.gov/.

In addition to caring for the community they serve, recipients are expected to be involved with workforce development activities, including health career recruitment and teaching and behavioral health. The CNMI CHCC Student Loan Repayment Program is expected to improve the number of primary care providers in medically underserved areas of the CNMI by working at CHCC, as well as improve the retention of health care providers in medically underserved areas by lessening the burden of large debt.

Please note this is a grant matching program so continuation from year to year is subject to continuation of both local and federal funds. For this reason, we cannot commit to funding past the initial year of commitment, but if you agree to participate, you will be obligated for the full time of initial service (2 years fulltime service; 4 years for part time service) if funding ends. We anticipate being able to continue on a year-to-year contract by mutual agreement after the initial commitment is met.

Previously awarded CNMI CHCC-SLRP recipients are eligible to apply, however will still need to go through the same competitive rating process as all other applicants.

Instructions for Submitting an Application

- Applications will be accepted beginning **February 20, 2024** through **March 15, 2024**. Contracts will be awarded on a competitive basis. (Criteria such as debt to income ratios are taken into consideration.)

- Before submitting an application, please speak with your supervisor at your prospective work site to ensure that they are willing to participate in the program and support your application submission.

- Please go to www.chcc.health to download application materials, follow the instructions, sign, and submit the completed application, with supporting documents, to the Division of Grants & Financial Integrity. **Applications and supporting documents cannot be submitted via email.**

- The following documents **MUST BE SUBMITTED** and **COMPLETED** for an application package to be considered for rating:
    1. Completed application.
    2. Personal Statement, Part D of the application.
    3. Certification of Work Site, Part G of the application.
    4. A letter of recommendation from the work site.
    5. Educational Debt Reporting Form, Part F of the application.
    6. Copy of current lender statements (dated within one month of applications submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name, current balance, account number, and the mailing address of the lender.
    7. Copy of current license or certification
    8. **Six (x6)** printed hard copies of the application and supporting documentation.

    ***Failure to comply with these requirements will result in an automatic rejection of application.**

- Notification of award decision will be sent out within 4 weeks following submission of complete application and background and credit checks. Please read the application instructions very carefully.

If you have questions regarding the application or eligibility, please e-mail the Grants Management Office at shawnalei.ogumoro@chcc.health or call staff via telephone at (670) 234-8950 ext. 3421/3451.

CNMI State Loan Repayment Program

Primary Care Health Professional Application *2023 – 2024 Grant Period*

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application.

PART A: PERSONAL INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Mailing Address: _____

City: _____ **Country:** _____ **State:** _____ **Zip:** _____

Phone Numbers (provide at least 2): (_____) _____ ☐ Hm ☐ Wk ☐ Cell

(_____) _____ ☐ Hm ☐ Wk ☐ Cell

Email Address: _____ ☐ Wk ☐ Personal

Social Security Number: _____ **Date of Birth:** _____

Gender:

☐ Male

☐ Female

☐ Transgender or non-binary or another gender

☐ Not Reported

Ethnicity:

☐ Hispanic/Latino

☐ Non-Hispanic/Non-Latino

Race:

☐ American Indian or Alaska Native ☐ Native Hawaiian or Other Pacific Islander

☐ Asian ☐ White or Caucasian

☐ Black or African American

☐ Other (please specify)**:** _____

Are you from a Rural Residential Background: ☐ Yes ☐ No

Are you from a Disadvantaged Background: ☐ Yes ☐ No

Veteran Status:

☐ Active Duty Military ☐ Not a Veteran

☐ National Guard ☐ Reservist

☐ Veteran – Prior Service ☐ Veteran – Retired

List languages you speak, read, and or write in addition to English (check all that apply):

1._____ ☐ Speak ☐ Read ☐ Write ☐ Basic medical training

2._____ ☐ Speak ☐ Read ☐ Write ☐ Basic medical training

PART B: QUALIFICATIONS AND ELIGIBILITY

1. Are you a United States citizen? ☐ Yes ☐ No

2. Do you have a current and unrestricted CNMI license to practice your profession ☐ Yes ☐ No

3. Do you owe an existing service obligation to another entity? ☐ Yes ☐ No
(If yes, please provide explanation in your personal statements, Part D of application)

4. Are you free of judgements arising from Federal debt? ☐ Yes ☐ No
(If no, please provide explanation in your personal statements, Part D of application)

5. Are you delinquent with any court ordered child support? ☐ Yes ☐ No
(If yes, please provide explanation in your personal statements, Part D of application)

6. Are you an NHSC Scholar or Alumni? ☐ Yes ☐ No
(If yes, please provide the date that your NHSC service obligation was completed: _____)

7. Did you apply for the NHSC Federal Loan Repayment Program? ☐ Yes ☐ No
(If yes, please indicate the date of submission: _____)

PART C: HEALTH PROFESSION INFORMATION PRIMARY DISCIPLINE

☐ Dentists (DDS or DMD)

☐ Certified Nurse-Midwife (CNM)

☐ Registered Dental Hygienist (RDH)

☐ Health Service Psychologist (HSP)

☐ Licensed Clinical Social Worker (LCSW)

☐ Psychiatric Nurse Specialist (PNS)

☐ Licensed Professional Counselor (LPC)

☐ Pharmacist

☐ Registered Nurse (RN)

☐ Substance Use Disorder Counselor

☐ Physician Assistant

Individual Discipline Specialty: (please circle applicable specialty)

☐ Adult

☐ Family Practice

☐ Family Practice – Geriatrics

☐ Family Practice w/OB

☐ General Practice

☐ Pediatrics

☐ Geriatrics

☐ Internal Medicine

☐ Women's Health

☐ Internal Medicine - Geriatrics

☐ OB/GYN

☐ Psychiatry

☐ Psychiatry - Geriatrics

☐ Psychology

☐ Public Health Dentistry

☐ None

Select Individual Key Services Provided:

☐ COVID-19 Treatment or Prevention Services

☐ Integrated Behavioral Health in Primary Care Services

☐ Substance Use Treatment Services

☐ Telehealth Services

☐ None of the Above

Select any HRSA/Bureau of Health Workforce program you have participated in prior to entering NHSC SLRP: (*Select ONLY if you attended any HRSA sponsored BHW program)

- [ ] Advanced Nursing Education
- [ ] Area Health Education Centers
- [ ] Behavioral Health Workforce Education & Training
- [ ] Centers of Excellence
- [ ] Childrens Hospital Graduate Medical Education
- [ ] Geriatric Workforce Enhancement Program
- [ ] Graduate Psychology Education
- [ ] Health Careers Opportunity Program
- [ ] Nurse Education Practice Quality & Retention
- [ ] Nurse Practitioner Residency
- [ ] Nursing Workforce Diversity
- [ ] Physician Assistant Training in Primary Care
- [ ] Postdoctoral Training in General Pediatric & Public Health Dentistry
- [ ] Predoctoral Training in General Pediatric & Public Health Dentistry & Dental Hygiene
- [ ] Preventive Medicine Residencies
- [ ] Primary Care Training & Enhancement
- [ ] Public Health Training Centers
- [ ] Scholarships for Disadvantaged Students
- [ ] Teaching Health Centers Graduate Medical Education
- [ ] Veterans Bachelor of Science in Nursing
- [ ] None of the Above
- [ ] Not Reported

Select the Medication Assisted Treatment (MAT) Services that you provide:

- [ ] Buprenorphine
- [ ] Buprenorphine plus counseling
- [ ] None

Do you hold a Substance Use Disorder License or Certificate?

☐ Yes ☐ No

Select HHS Priority Topic Area in which an Individual Received Training:

☐ COVID-19 related training

☐ Health Equity/Social Determinants of Health

☐ Substance Use Treatment

☐ Related to Maternal Health

☐ Provider Resilience Training

☐ Medication Assisted Treatment (MAT) for SUD/OUD

☐ Integrated Behavioral Health in Primary Care

☐ None of the Above

PART D: PERSONAL STATEMENTS

Attach your personal statements to the application. Your statements must be typed and about one page in length. Restate and number each question along with your answer.

1. Describe your short and long-term goals and commitment to improving healthcare from your practice site.

2. Describe a leadership experience in which you made a difference at CHCC.

3. Describe a specific activity that has been important in strengthening your commitment to healthcare.

PART E: QUESTIONNAIRE

1. Where did you hear about the CNMI State Loan Repayment Program?

☐ Work (employer/co-worker)

☐ HRSA State Loan Repayment Website

☐ CHCC website

☐ Family member, friend, or acquaintance

☐ Other source (please specify): _____

PART F: EDUCATIONAL DEBT REPORTING

Directions:

- List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be completed even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete, and it will not be reviewed.
- You must submit evidence of the educational debts listed below. If your loans have been consolidated, submit proof of consolidation.
- Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted. Online printouts are acceptable if they include all the required information.
- You may only submit proof of debt for those loans obtained during your undergraduate or graduate education which led to your current license/certification as a qualified provider for this program. Make sure that the Lender Address listed below corresponds with the address to which payments are sent to. This address must also appear on the lender statements you have included in your application packet.

School:_____ Date of Graduation: _____
City: _____ State: _____ Zip: _____
Highest Degree Held: _____
Postgraduate Training: _____ Year Completed: _____
Profession License #: _____ Certificate #: _____
National Provider Identity#: _____

1. Lender Name: _____
Lender Payment Address: _____
City: _____ State: _____ Zip +4: _____
Account Number: _____ Current Loan Balance: $_____

---

2. Lender Name: _____
Lender Payment Address: _____
City: _____ State: _____ Zip +4: _____
Account Number: _____ Current Loan Balance: $_____

---

3. Lender Name: _____
Lender Payment Address: _____
City: _____ State: _____ Zip +4: _____
Account Number: _____ Current Loan Balance: $_____

PART G: CERTIFICATION OF WORK SITE (to be filled out by work site Supervisor)

The completed form must bear an original ink signature and be returned with the provider's application. Photocopies and faxed copies are not acceptable. In addition, a supervisor or authorized representative must prepare a letter of recommendation explaining why the provider would be a good candidate for this program.

Applicant Name: _____

Work Site Information

Please list the actual street address of the practice setting(s) where the applicant is working or has entered into an agreement to services.
Department/Unit Name: _____
Address: _____
City: _____ State: _____ Zip +4: _____ Type of Practice: ☐ Public ☐ Private, not-for profit
Contact Person (person who will sign MOU below): _____
Title: _____
Telephone Number: (____) _____ Email Address: _____

Memorandum of Understanding (MOU) Information

As an approved practice site in the Health Professions Shortage Area (HPSA) in CNMI where a participant in the CNMI State Loan Repayment Program is or will be employed, the above-named Site agrees to the following terms:

1. Site shall accept all public insurances, including Medicare and Medicaid.
2. Site will provide discounts for individuals with limited incomes (i.e.: using a sliding fee scale) as outlined below:
   a. For those with annual incomes at or below 100 percent of the HHS Poverty Guidelines, Site shall provide services at no charge or at a nominal charge.
   b. For individuals between 100 and 200 percent of the HHS Poverty Guidelines, the Site shall provide a schedule of discounts, which should reflect a nominal charge coverage from a third party (either public or private).
   c. Site may charge for services to the extent that payment will be made by the third party.
3. Site will provide to the CHCC the following:
   a. A copy of the patient fee schedule annually.
   b. A schedule of salaries paid to all professionals in the field of the Program Participant (on whose behalf CHCC is repaying the loan) to demonstrate parity of payment to loan repayers.
   c. A monthly confirmation of full-time (or part-time as appropriate) employment of Program Participant.
4. Participant shall remain at the worksite for the duration of the service obligation.

Site supervisor acknowledges and agrees to the above terms.

Name: _____ Title: _____

Signature: _____

Date: _____

Applicant Name: _____

PART H: APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum of two years of service. I authorize representatives of the Commonwealth Healthcare Corporation to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application. I also authorize representatives of the Commonwealth Healthcare Corporation to investigate my background and qualifications which may obtain information relating to my criminal history record as well as obtain a copy of my credit report for purposes of evaluating whether I am qualified for the CNMI State Loan Repayment Program for which I am applying. I understand that the Commonwealth Healthcare Corporation will utilize an outside firm(s) to assist it in checking such information, and I specifically authorize such an investigation by information services and outside entities of the company's choice. I also understand that I may withhold my permission and that in such a case, no investigation will be done, and my application for the State Loan Repayment Program will not be processed further.

The criminal history record, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct committed as a juvenile. I understand that as long as I remain a participant, the criminal history records check and credit check may be repeated at any time.

I hereby affirm that my answers to the foregoing questions are true and correct and that I have not knowingly withheld any fact of circumstances that would if disclosed, affect my application unfavorably. I understand that false information submitted in this application may result in discharge.

I, the undersigned, do, for myself, my heirs, executors and administrators, hereby remise, release, and forever discharge and agree to indemnify the Commonwealth Healthcare Corporation and each of their officers, directors, employees and agents and hold them harmless from and against any and all causes of actions, suits, liabilities, costs, debts, and sums of money, claims and demands whatsoever (including claims for negligence, gross negligence, and/or strict liability of the Commonwealth Healthcare Corporation) and any and all related attorney's fees, court costs, and other expenses resulting from the

investigation of my background in connection with my application to become a recipient of the CNMI State Loan Repayment Program.

Signature: _____ Date: _____

Print Name: _____

Submission Checklist:

- ☐ Completed Application
- ☐ Personal Statements
- ☐ Educational Debt reporting Form
- ☐ Current Lender Statements
- ☐ Certification of Participating Site
- ☐ Copy of Current License or Certification
- ☐ Letter of Recommendation from Site