

Northeast Delta Dental Tri-State Loan Payment Reimbursement Program Application – Spring 2024 Cycle

Timeline: This application is due May 15, 2024.

Applicants should submit completed applications to loanprogram@bistatepca.org by May 15, 2024.

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

APPLICANT NAME: _____

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 was in the Fall of 2022 and there were two cycles in 2023. There will be two subsequent application cycles in 2024. 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 a Reimbursement Certificate.

Reimbursements are available up to \$50,000/year for three years if funding permits. **These payments will be considered taxable income, and you should consult a tax professional before accepting an award.** All payments will be made annually in December to the applicant. If the total payoff amount at the end of November is less than the award total, then the payment to the applicant will be equal to the total payoff amount. 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.

State-Specific Priorities for Awards		
Maine	New Hampshire	Vermont
<ul style="list-style-type: none"> - Northern/Western Rural Areas - Oral Surgeons - Orthodontists - Adult Medicaid Panel - General Dentist - Patients with Special Needs - Serves Intellectually Disabled Population (Pediatric Primarily) 	<ul style="list-style-type: none"> - Adult Medicaid Panel - General Dentists - Manchester (urban) - Oral Surgeons North and Southwest - Patients with Special Needs / Disabilities - NEDD Participation Preferred 	<ul style="list-style-type: none"> - 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

- Services Under Sedation	- Prosthodontist
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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 work 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 participate 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:

1. Serving in a practice that is in an underserved geographic area within ME, NH, or VT 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.
2. Engaging in full time practice (which can be in multiple locations).
3. Living in ME, NH, or VT as a resident.
4. Committing to treating a high number of adult and pediatric Medicaid patients (this can be both for the individual and within the entire practice).
5. Willing to relocate to ME, NH, or VT.
6. 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 actions (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? Yes _ No _

If yes, please explain: _____

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? Yes _ No _

If yes, please explain: _____

Legal Name	Practice Name and Address	
Home 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.

____ The applicant understands that any awards through this program are considered taxable income.

Loan Information:

Outstanding Loan Debt Amount(s):	Lender(s):

*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 or are currently participating in other state/federal loan programs? ___YES___NO. Please indicate yes if you have applied for another state or federal program and are awaiting a decision. If yes, please explain why you are not participating in these other programs and instead seeking funding through this program. Please note that preference is given to those who do not qualify for and participate in these other programs.
3. Please describe the community where you are (or will be) practicing dentistry. If you are practicing in more than one community, please provide information on all practice locations. Specifically, please describe how the community is underserved or the populations you are treating are underserved. Include a listing of the towns from which you draw patients.
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 explain.
7. How many Medicaid patients are on your panel? If you are working in multiple practices, please provide numbers for all practices.)
8. What is the percentage of Medicaid patients on your panel? (If you are working in multiple practices, please provide percentage for all practices.)
9. What is the anticipated number of Medicaid patients you will treat in the next year? If you are working in multiple practices, please provide numbers for all practices.)
10. 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.
11. How many hours do you work each week?
12. Where are you licensed to practice?
13. Is licensure pending in any other state?

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