CalHealthCares
Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Program

Application Instructions

Application Cycle:
April 1 – April 26, 2019 (11:59PM PST)
Table of Contents

General Description 3
Program Description 3
Loan Repayments 3
Practice Support Grants for Dentists 4
Program Requirements 5
Application Submission 6
Getting your Questions Answered 7
Electronic Application
  Eligibility 8 – 13
  Communications 13 – 14
  Applicant Information 14 – 16
  Employer Information 17 – 18
  Educational History 18
  Funds Requested 18 – 20
  HPSA Score 20 – 21
  Patient Caseload 21 – 22
  Personal Statement/Letter of Recommendation 22 – 23
  Attestations 23 – 24
  Program Requirements 24 – 25
  Permissions 25
Review and Selection Process 26
General Description
The Budget Act of 2018 appropriates a specified portion of the California Healthcare, Research and Prevention Tobacco Tax Act (Proposition 56) revenue to the Department of Health Care Services (DHCS) for state fiscal year (FY) 2018-19. Senate Bill 849 (Chapter 47, Statutes of 2018) established the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program (LRP) and appropriates $220 million for a loan assistance program for recently graduated physicians ($190 million) and dentists ($30 million). This program is hereby known as the CalHealthCares Program. DHCS has contracted with Physicians for a Healthy California (PHC) to administer the CalHealthCares Program.

Approximately $41.8 million will be available annually for funding in FY 2018-19 through FY 2022-23. The following table illustrates the funding available for the FY 2018-19 cycle. This will result in approximately 125 physicians and 20 dentists receiving an award annually – assuming all awards are $300,000 per awardee. Per Proposition 56, up to five percent of all available funds may be directed for administrative expenses associated with administering the program.

Table: Approximate Funding and Awarding Available in FY 2018-19

<table>
<thead>
<tr>
<th>Profession</th>
<th>Type of Award</th>
<th>Funding Available</th>
<th>Number of Awards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>Loan Repayment</td>
<td>$36.1 million</td>
<td>125</td>
</tr>
<tr>
<td>Dentists</td>
<td>Loan Repayment</td>
<td>$5.7 million</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Practice Support Grants</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: these numbers are approximate

Program Description
Per Senate Bill 849, the Medi-Cal Physicians and Dentists Loan Repayment Program – hereby known as CalHealthCares – was created to provide loan assistance payments to qualifying, recent graduate physicians and dentists that serve beneficiaries of existing health care programs – namely Medi-Cal and Medi-Cal Dental, California's Medicaid program. Recent graduate physician is defined as having graduated from either a residency program or completed a fellowship program within the last five years (on or after January 1, 2014). Recent graduate dentist is defined as having graduated from dental school or completed a dental residency program within the last five years (on or after January 1, 2014). Qualifying physicians may apply for a loan repayment program. Qualifying dentists may apply for either a loan repayment program or a practice support grant – qualifying dentists may not apply for both. All medical and dental specialists are eligible to apply.

Loan Repayments
Eligible physicians and dentists may receive a loan repayment of up to $300,000 in exchange for a five-year service obligation. During that period, awardees are required to maintain an individual direct patient caseload of 30 percent or more Medi-Cal beneficiaries in addition to other requirements.
Payments will be made in arrears, in essence after every one-year of service. Each annual payment will be 20 percent of the total award. As such, an awardee that receives a loan repayment of $300,000 would receive a $60,000 payment after each one year of service, assuming that the awardee also meets the other requirements (i.e. active and unrestricted license, in good standing with the Medi-Cal program, minimum 30 percent Medi-Cal caseload, etc.). The actual loan repayment award is based on the current balance of qualifying student loans incurred. Payments will be made directly to the awardee. Awardees are responsible for keeping their student loans in good standing.

<table>
<thead>
<tr>
<th>Loan Repayments: Funding Disbursement (assuming $300,000 award)</th>
</tr>
</thead>
<tbody>
<tr>
<td>When money will be awarded</td>
</tr>
<tr>
<td>After first year</td>
</tr>
<tr>
<td>After second year</td>
</tr>
<tr>
<td>After third year</td>
</tr>
<tr>
<td>After fourth year</td>
</tr>
<tr>
<td>After fifth year</td>
</tr>
</tbody>
</table>

Per the Internal Revenue Service (IRS), certain educational loan repayment or loan forgiveness programs to help provide health services in certain areas are exceptions to cancellation of debt and therefore reportable but not taxable income. Applicants are advised to consult with a tax advisor to address questions about whether this loan repayment is considered reportable and/or taxable income. The information contained in this document should not be considered tax advice! For more information, visit the IRS website for more information: [https://www.irs.gov/taxtopics/tc431](https://www.irs.gov/taxtopics/tc431)

**Practice Support Grants for Dentists**

Dentists may apply for either a loan repayment or a practice support grant. Eligible dentists may apply for a practice support grant up to $300,000 to expand and/or relocate their practice to an underserved area or open a new location of an existing dental practice in an underserved area, in exchange for a ten-year service commitment. Eligible dentists may not apply for both the loan repayment and the practice support grant – the electronic application will ask eligible dentists to choose an option. Dentists applying for the practice support grant are not required to have student loan debt. Further, dentists applying for the practice support grant are required to have graduated in the last fifteen years (on or after January 1, 2004).

The funding disbursement is 10 percent ($30,000) after the initial contract signing, 23 percent ($69,000) in year one, and 67 percent ($50,250 each year) across the remaining four years and then monitor the remaining five years to ensure compliance. For those that breach their contract, awardees will be required to repay a portion of their award. Details will be provided in
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APPLICATION INSTRUCTIONS

the awardee contract. The table below is an example of the funding disbursement for a dentist who has been awarded the full amount of $300,000.

<table>
<thead>
<tr>
<th>When money will be awarded</th>
<th>Percentage of total awarded</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>After initial contract signing</td>
<td>10%</td>
<td>$30,000</td>
</tr>
<tr>
<td>After first year</td>
<td>23%</td>
<td>$69,000</td>
</tr>
<tr>
<td>After second year</td>
<td>16.75%</td>
<td>$50,250</td>
</tr>
<tr>
<td>After third year</td>
<td>16.75%</td>
<td>$50,250</td>
</tr>
<tr>
<td>After fourth year</td>
<td>16.75%</td>
<td>$50,250</td>
</tr>
<tr>
<td>After fifth year</td>
<td>16.75%</td>
<td>$50,250</td>
</tr>
</tbody>
</table>

Practice support grants are typically considered reportable and taxable income. Applicants are advised to consult with a tax advisor to address questions about whether this loan repayment is considered reportable and/or taxable income. The information contained in this document should not be considered tax advice!

Program Requirements
If awarded, applicants will be required to comply with the following general requirements for this program:

- Maintain an individual direct-patient caseload of 30 percent Medi-Cal beneficiaries
- Maintain a current and non-restricted license to practice in the state of California
- Be a Medi-Cal provider in good standing without existing suspensions, disbarments or revocations
- Make payments and stay current and in good standing with educational loans
- Provide semi-annual and annual information to verify program compliance
- Provide timely and updated information to PHC; for example, but not limited to change in contact information, place of employment and/or employment status

Awardees may be considered in breach of their contract if they are unable to comply with the terms of their contract. If an awardee does not meet the terms of their contractual obligations, they will not be eligible for the annual loan repayment. For example, if an awardee moves out of state or changes employment and no longer has an individual direct patient caseload of 30 percent Medi-Cal, the awardee is considered in breach of the contract and an annual payment will not be provided for that year. An awardee may be terminated from the program if there are two consecutive years in which they do not comply with the terms of their contract. For example, an awardee that fails to meet the terms of their contract in year two, will not receive an annual payment for their second year in the program. They may remain in the program and will be monitored for program compliance in future years. In this example, the awardee
may be terminated from the program if they also fail to meet the terms of the contract in year three. DHCS will consider each breach of contract separately and individually. DHCS has discretion to consider extenuating circumstances determining whether the awardee may remain in the program.

Awardees will be required to submit semi-annual and annual statements regarding compliance with program requirements such as the active status of their employment, Medi-Cal patient caseload and the status of educational loans. Payments will not be made if an awardee receives a written performance improvement plan from their employer related to standard of care during that one-year time frame.

Importantly, awardees are required to maintain a caseload with a minimum of 30 percent Medi-Cal beneficiaries. A caseload may be defined as annual office visits, panel of patients, payer mix, practice and/or time. The goal of this program is to support existing Medi-Cal providers to maintain and/or increase their Medi-Cal caseload as well as incentivize providers with no or low Medi-Cal beneficiaries to increase their caseload of Medi-Cal beneficiaries. Applicants will be asked to explain how they derived the 30 percent Medi-Cal caseload. This information should be considered auditable self-attestation – this means that applicants will self-attest and must be able to document that they will be providing a minimum of 30 percent Medi-Cal beneficiaries in their caseload. This self-attestation is subject to an audit.

Application Submission
If you are applying for the loan repayment program, the following documents are required to be submitted at the time of submission for an application to be considered complete:

- Educational loan statements
- Employment verification form
- One letter of recommendation from your clinical supervisor if you are a current student, resident, and/or fellow

If you are applying for the practice support grant, the following documents are required to be submitted at the time of submission for an application to be considered complete:

- Employment verification form
- Valid business plan that details your business expansion and/or relocation plans or your plan to open a new location of an existing business in an underserved area

Please note that only the applicant is able to upload these documents onto the CalHealthCares’ electronic application. Applicants will not be able to mail or email these documents separately. Applications that don’t have all the required documents will be considered incomplete and therefore ineligible for funding.
Please note that applicants are not able to make changes to their application once the application has been submitted. If an applicant realizes s/he has made a mistake in their application, they may submit additional information to staff at CalHealthCares@phcdocs.org during the application cycle. Additional information will not be reviewed and considered if submitted after the deadline. Late applications may be considered only after all timely-submitted applications have been reviewed and evaluated, and awarding decisions made. If there are remaining funds, then PHC may consider reviewing late applications. This is not a guarantee and applicants should strive to submit their application online before the deadline.

Applying
Applications are submitted electronically. Applications will not be accepted in hard copy form. Each applicant must create an individual account with a username and password. An applicant must register as a new user to view and complete application materials. Applicants are encouraged to save their application frequently. Once a tab in the application is completed and saved, the system allows the applicant to go back and edit as necessary. However, once an application is submitted, an applicant will not have access to the application to make changes. Please be sure to thoroughly review the application before clicking the final submission button. Applicant will have the ability to download their submitted application as a PDF file. If you have technical questions, please email us at CalHealthCares@phcdocs.org and we will reply within two business days.

Funding is approximate and applying is not a guarantee of funding. PHC has convened an advisory council that will make recommendations to the Department of Health Care Services. DHCS will have the final authority in terms of who gets awarded.

The deadline to submit the application is 11:59pm (PST) on April 26, 2019. All applications received by this deadline will receive full consideration for funding. If there are remaining funds after all applications submitted on time are reviewed and awarded, late applications may be considered. Late applications will only be considered if there are remaining funds.

Getting your Questions Answered
There are various ways to get answers to your questions. First and foremost, please read this Application Instructions manual. Secondly, read the Frequently Asked Questions (FAQ) document for more information. Applicants are also encouraged to attend a scheduled webinar. The webinars will provide an overview of the application as well as provide applicants with an opportunity for real-time responses to their questions. Below is the schedule of webinars. Please visit CalHealthCares.org for information on how to sign up for these webinars.
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How to Use this Document
This document will provide a step-by-step view of the questions on the CalHealthCares application (the electronic application section) and a description and/or explanation for that section. The section titled “Electronic Application” is the information that the applicant will see on the electronic application. The section titled “Instructions for Completing the Application” provides additional information to guide the applicant in completing the application.

Electronic Application
Welcome to the CalHealthCares online application. Eligible physicians may apply for a loan repayment up to $300,000 in exchange for a five-year service obligation. Eligible dentists may apply for either a loan repayment up to $300,000 in exchange for a five-year service obligation or a practice support grant up to $300,000 in exchange for a ten-year service obligation. All awardees are required to maintain a patient caseload of 30 percent or more Medi-Cal beneficiaries.

Before you apply, please read the Application Instructions and Frequently Asked Questions (FAQ). The Application Instructions and FAQs contain answers to commonly asked questions, information about important deadlines, as well as instructions for completing the application. Please also consider attending a webinar to receive additional information about the program – more information on the webinars is available at CalHealthCares.org.

The deadline to submit your application is April 26, 2019 at 11:59PM (PST). You may save the application and continue to complete the online application throughout the open application period. If there are remaining funds after all applications submitted on time are reviewed and awarded, late applications may be considered.

Funding for this program was made possible by Proposition 56 and Senate Bill 849 (Chapter 47, Statutes of 2018).

Instructions for Completing the Application
This first page provides the applicant with background information on the CalHealthCares program.

Electronic Application – Step 1: Eligibility
Eligibility
Thank you for applying to the CalHealthCares program.

To be eligible for consideration, all the following must be true at the time of application, and before funds are released.

Please check the box that describes you (can only check one):

- □ I am a current licensed healthcare provider (physician or dentist)
- □ Physician
- □ Dentist
APPLICATION INSTRUCTIONS

- Applying for the loan repayment
- Applying for the practice support grant

☐ Current dental student, medical/dental resident, and/or fellow

**For physicians:**

Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):

- I have an unrestricted license and am in good standing with the Medical Board of California and/or Osteopathic Medical Board of California
- I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- I graduated from an ACGME-approved residency program and/or completed a fellowship within the last five years (on or after January 1, 2014)
- I have existing educational loan debt incurred while pursuing my medical degree
- I am not currently participating in another loan repayment program
- I will practice in California
- If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
- I am employed, self-employed or have a validated offer of employment

**For dentists applying for the loan repayment:**

Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):

- I have an unrestricted license and am in good standing with the Dental Board of California
- I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
- I graduated from dental school, residency, and/or dental fellowship program within the last five years (on or after January 1, 2014)
- I have existing educational loan debt incurred while pursuing my dental degree and/or dental residency program
- I am not currently participating in another loan repayment program
- I will practice in California
- If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
- I am employed, self-employed or have a validated offer of employment

**For dentists applying for the practice support grant:**

Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):

- I have an unrestricted license and am in good standing with the California Dental Board
- I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
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☐ I have graduated from dental school, residency, and/or dental fellowship program within the last 15 years (on or after January 1, 2004)
☐ I am not currently participating in another loan repayment as of July 1, 2019
☐ I will practice in California
☐ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
☐ I am willing to relocate my practice if I receive the practice support grant and establish a new Medi-Cal Dental office in one of the target counties

If you are a current dental student, medical/dental resident, and/or fellow, you must attest that the following will be true as of July 1, 2019 (you must check all boxes to be considered eligible to apply):

☐ I have an unrestricted license and am in good standing with the Medical Board of California, Osteopathic Medical Board of California, or Dental Board of California
☐ I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
☐ I have graduated from a dental school and/or physician or dental residency program, and/or fellowship
☐ I have existing educational loan debt incurred while pursuing my medical and/or dental degree
☐ I am not currently participating in another loan repayment program
☐ I will practice in California
☐ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
☐ I am employed, self-employed or have a validated offer of employment

Instructions for Completing the Application

This page is critical. Applicants must check off that they are eligible to apply based on the criteria set forth. If applicants don’t check off all boxes, the electronic application will not allow you to continue further. You will receive an error message and have the opportunity to explain why you think you are still eligible to apply.

Eligibility

On this page, you will be required to self-select one of these options:

- Physician
- Dentist applying for loan repayment
- Dentist applying for practice support grant, or
- Current dental student, or a medical/dental resident, and/or fellow

This allows the application to provide you with only the questions that are relevant to you as an applicant. To be eligible for this loan repayment program, the following statements must be true of the applicant:

For physicians:

Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):
□ I have an unrestricted license and am in good standing with the Medical Board of California and/or Osteopathic Medical Board of California
□ I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
□ I graduated from an ACGME-approved residency program and/or completed a fellowship within the last five years (on or after January 1, 2014)
□ I have existing educational loan debt incurred while pursuing my medical degree
□ I am not currently participating in another loan repayment program
□ I will practice in California
□ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
□ I am employed, self-employed or have a validated offer of employment

For dentists applying for the loan repayment:
Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):
□ I have an unrestricted license and am in good standing with the Dental Board of California
□ I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
□ I graduated from dental school, and/or residency program within the last five years (on or after January 1, 2014)
□ I have existing educational loan debt incurred while pursuing my dental degree or dental residency
□ I have existing educational loan debt incurred while pursuing my dental degree
□ I am not currently participating in another loan repayment program
□ I will practice in California
□ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
□ I am employed, self-employed or have a validated offer of employment

For dentists applying for the practice support grant:
Please check all the boxes that describe you (you must check all boxes to be considered eligible to apply):
□ I have an unrestricted license and am in good standing with the California Dental Board
□ I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider
□ I have graduated from dental school, residency, and/or fellowship program within the last 15 years (January 1, 2004)
□ I am not currently participating in another loan repayment program as of July 1, 2019
□ I will practice in California
□ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries
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□ I am willing to expand and/or relocate my practice if I receive the practice support grant and establish a new Medi-Cal Dental office in one of the target counties.

Medical students are not eligible for CalHealthCares. Medical and/or osteopathic residents and/or fellows are eligible to apply as long as the statements below are true as of July 1, 2019. Dental students, residents and/or fellows are eligible to apply as long as the statements below are true as of July 1, 2019. If you are a current dental student, medical/dental resident, and/or fellow, you must attest that the following are true as of July 1, 2019 (you must check all boxes to be considered eligible to apply):

□ I have an unrestricted license and am in good standing with the Medical Board of California, Osteopathic Medical Board of California, or Dental Board of California

□ I am an active enrolled Medi-Cal provider without existing suspensions, disbarments or revocations, or have submitted an application to become a Medi-Cal provider

□ I have graduated from a dental school, medical/dental residency program and/or completed a fellowship

□ I have existing educational loan debt incurred while pursuing my medical and/or dental degree

□ I am not currently participating in another loan repayment program

□ I will practice in California

□ If awarded, I will have my patient caseload comprised of a minimum of 30 percent Medi-Cal beneficiaries

□ I am employed, self-employed or have a validated offer of employment

Physicians (Doctors of Medicine and Doctors of Osteopathic Medicine) practicing medicine in primary, specialty and sub-specialty care are eligible to apply. Dentists (Doctor of Dental Surgery or Doctor of Medicine in Dentistry) practicing general and/or specialty dentistry are eligible to apply.

Graduates of national and/or international schools of medicine are eligible to apply.

Applicants must be eligible to work in the United States for the terms of the contract.

Individuals that are listed in the Medicaid bar list or the Medi-Cal suspended list are not eligible to apply.

CalHealthCares is intended to support existing physicians and dentists that provide care to Medi-Cal beneficiaries as well as incentivize new physicians and dentists to increase their participation in the Medi-Cal Program. As such, competitive applicants may include those that are already at 30 percent or more Medi-Cal as well as applicants that are below 30 percent Medi-Cal and commit to increasing their participation to 30 percent Medi-Cal.

Applicants that have participated and successfully completed another loan repayment program are eligible to apply. Applicants that are currently pursuing loan forgiveness through the national Public Service Loan Forgiveness Program are eligible to apply. Applicants that are currently participating in another loan repayment program and will not complete their service obligation by July 1, 2019 are not eligible to apply. This may include employer-sponsored, local, regional, state and/or national loan repayment programs. For example, physicians currently participating in the Steven M. Thompson Loan Repayment Program and/or the National Health Services Corp (California’s State Loan Repayment Program) are not eligible to apply. Applicants may apply once they have successfully completed the terms of agreement of their loan repayment program. Participating and successfully completing a loan repayment program will not impact an applicant’s eligibility.
Applicants may provide direct patient care in various settings such as a solo, group, clinic and/or hospital-based setting. If an applicant is part of a medical group, independent physician/dentist association or hospital-based practice, the applicant must still have a minimum of 30 percent of their directly-assigned individual patient population comprised of Medi-Cal beneficiaries.

### Program Requirements

The following will be required of applicants awarded a **loan repayment**. Failure to comply with these requirements may result in a breach of contract. Those who have breached their contract may not be eligible for an annual payment.

- Maintain an active and unrestricted license to practice by either the Medical Board of California, Osteopathic Medical Board of California or the Dental Board of California
- Remain a current, enrolled and active Medi-Cal provider without existing suspensions, disbarments or revocations
- Maintain your educational loan debts in good standing. Good standing for the purposes of student loan debt is defined as not being in default. Applicants may have student loans that are in deferment and/or forbearance
- Not be currently participating in or enter into another loan repayment program
- Practice in California and maintain an individual direct care patient practice of a minimum of 30 percent Medi-Cal beneficiaries for five years

The following will be required of applicants awarded a **practice support grant**. Failure to comply with these requirements may result in a breach of contract. Those who have breached their contract may not be eligible for an annual payment.

- Maintain an active and unrestricted license to practice by the Dental Board of California
- Remain a current, enrolled and active Medi-Cal Dental provider without existing suspensions, disbarments or revocations
- Not enter into another loan repayment program and/or practice support grant
- Practice in California and maintain an individual direct care patient practice of a minimum of 30 percent Medi-Cal beneficiaries for ten years

### Documentation to be Provided Upon Request

Applicants and awardees may be asked to provide documentation regarding but not limited to the following:

- Current medical and/or dental license by the Medical Board of California, Osteopathic Medical Board of California and/or Dental Board of California
- Proof of employment
- Evidence of your individual patient population with a minimum of 30 percent Medi-Cal beneficiaries
- Proof of current student loan debt
- Proof of enrollment as a fee for service Medi-Cal provider and/or California Children's Services specialty provider
- Proof of contracts with Medi-Cal managed care plans
- Proof of agreements with safety net providers such as designated public hospitals and/or federally qualified health centers
Electronic Application – Step 1: If Applicants Don’t Meet Eligibility

Applicants that don’t meet the criteria as outlined above
If you do not meet the aforementioned criteria, but you still think you are eligible, please provide a detailed yet succinct explanation here and a program representative will reply within three business days.

Name:  
Phone Number:  
Email:  
Explanation: (text box with 100 words max)

Instructions for Completing the Application

Applicants that don’t meet the criteria as outlined above may provide an explanation as to why they think they may still be eligible for the program. If you do not meet the aforementioned criteria, but you still think you are eligible, please provide a detailed yet succinct explanation here. You will be limited in your explanation to 100 words.

Please include your name, phone number, email and a succinct explanation. A program representative will reply within five business days. PHC will consider each request for reconsideration separately and individually and make a recommendation to DHCS for consideration. DHCS has discretion to consider extenuating circumstances determining whether an applicant may be eligible for the program.

Electronic Application – Step 2: How You Head About Us

How did you hear about us?
Please tell us how you heard about the CalHealthCares program. Check all that apply.

- Internet
  - Website: _____ (text box)
- Email
  - From: _____ (text box)
- Social media (Linked In or Facebook or Twitter)
  - From: _____ (text box)
- Flyer/Mailer
- Presentation
- Specialty Society
  - From: _____ (text box)
- Professional Association
  - From: _____ (text box)
- Other (text box)

Instructions for Completing the Application
How did you hear about us?
Please check all the options that apply to describe how you heard about the CalHealthCares program. Your responses will help us with future outreach and marketing efforts.

<table>
<thead>
<tr>
<th>Electronic Application – Step 2: Future Communications</th>
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</thead>
<tbody>
<tr>
<td>Future Communication</td>
</tr>
<tr>
<td>Please tell us how you want us to share information about the CalHealthCares program in the future. Check all that apply.</td>
</tr>
<tr>
<td>□ Internet</td>
</tr>
<tr>
<td>□ Email</td>
</tr>
<tr>
<td>□ Social media (LinkedIn or Facebook or Twitter)</td>
</tr>
<tr>
<td>□ Flyer</td>
</tr>
<tr>
<td>□ Letter</td>
</tr>
<tr>
<td>□ Presentation</td>
</tr>
<tr>
<td>□ Other (text box)</td>
</tr>
</tbody>
</table>

Instructions for Completing the Application

| Future Communication |
| Please check the option that best represents how you want to hear about future CalHealthCares funding opportunities. |

<table>
<thead>
<tr>
<th>Electronic Application – Step 3: Applicant Information</th>
</tr>
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<tbody>
<tr>
<td>Applicant Information</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Personal Address</td>
</tr>
<tr>
<td>Work Phone Number</td>
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<tr>
<td>Personal Cell Number</td>
</tr>
<tr>
<td>Work Email</td>
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<tr>
<td>Personal Email</td>
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</table>

<table>
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<tr>
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<tbody>
<tr>
<td>Female</td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Transgender: male to female</td>
</tr>
<tr>
<td>Transgender: female to male</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender (check the box that best describes your current gender identity)</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Male</td>
</tr>
<tr>
<td>Transgender: male to female</td>
</tr>
<tr>
<td>Transgender: female to male</td>
</tr>
<tr>
<td>Non-Binary (neither male nor female)</td>
</tr>
<tr>
<td>Another gender identity</td>
</tr>
</tbody>
</table>
Date of Birth

Race/Ethnicity (for outreach and reporting purposes only)
American Indian/Alaskan Native
Asian/Pacific Islander
Black or African American
Hispanic or Latino
White, Non Hispanic, Non Latino

Current license number: (text box)

National Provider Index Number: (text box)

Languages spoken at work: (drop down menu of Medi-Cal threshold languages and text box for other languages) need to add option for up to three languages

Specialty: (drop down menu) need to add specialties

Last four digits of social security number and/or individual taxpayer identification number: (text box)

Have you participated in another loan repayment program? (drop down menu of yes or no) If yes, please describe the program, the requirements and whether you complete the program. (text box with 100 words maximum)

Instructions for Completing the Application

Applicant Information
Please provide contact information as well as other demographic information. Please ensure that the information for address, phone number and email are accurate as PHC will use this contact information to communicate with applicants regarding awards status, contracts, payments, etc.

Name
Please provide your name as it appears on your medical, osteopathic, or dental license.

Address
Please provide your home address. PHC will use this address to communicate with applicants and awardees.

Work Phone Number
Please provide your direct work phone number. Please don't include a general line to your place of practice.

Personal Cell Number
Please provide your personal cell number. Your cell phone number and your personal email will be PHC’s primary form of communication.

Work Email
Please provide your work email.

Personal Email
Please provide your personal email. Your cell phone number and your personal email will be PHC’s primary form of communication.
**APPLICATION INSTRUCTIONS**

<table>
<thead>
<tr>
<th>Field</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Sex</td>
<td>Please choose the option that best describes you.</td>
</tr>
<tr>
<td>Gender</td>
<td>Please choose the option that best describes you.</td>
</tr>
<tr>
<td>Date of Birth</td>
<td>Please provide your date of birth.</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>Please choose the option that best describes you. Demographic information such as gender, date of birth, and race/ethnicity will not be used to determine an applicant’s eligibility for funding. This information is being collected solely for statistical purposes.</td>
</tr>
<tr>
<td>Current License Number</td>
<td>Please provide your medical license information (letter followed by up to a six-digit number), osteopathic license number (up to a five-digit number), or dental license number (up to a five-digit number).</td>
</tr>
<tr>
<td>National Provider Index Number</td>
<td>Please provide your ten-digit National Index Provider Number.</td>
</tr>
<tr>
<td>Languages Spoken at Work</td>
<td>Please identify languages you may speak at work. Languages spoken at work will be verified by your supervisor through the employer verification form.</td>
</tr>
<tr>
<td>Specialty</td>
<td>Please choose the option that best describes your medical or dental specialty.</td>
</tr>
<tr>
<td>Last four digits of social security number and/or individual taxpayer identification number</td>
<td>Please provide the last four digits of either your social security or individual taxpayer identification number.</td>
</tr>
</tbody>
</table>

Applicants that have participated and successfully completed another loan repayment program are eligible to apply. Applicants that are currently pursuing loan forgiveness through the national Public Service Loan Forgiveness Program are eligible to apply.

Applicants that are currently participating in another loan repayment program and will not complete their service obligation by July 1, 2019 are not eligible to apply. This may include employer-sponsored, local, regional, state and/or national loan repayment programs. For example, physicians currently participating in the Steven M. Thompson Loan Repayment Program and/or the National Health Services Corp (California's State Loan Repayment Program) are not eligible to apply. Applicants may apply once they have successfully completed the terms of their agreement of their loan repayment program. Participating and successfully completing a loan repayment program will not impact an applicant’s eligibility.

**Electronic Application – Step 4: Employer Information**

| Employer Information | Please fill out the table below with information regarding your current employer. For individuals that are self-employed, please note “self” on the section that asks for supervisor information. |

DHCS has contracted with Physicians for a Healthy California to administer CalHealthCares.

(916) 551-2579
CalHealthCares.org
CalHealthCares@phcdocs.org
**APPLICATION INSTRUCTIONS**

### Table Employer Information

<table>
<thead>
<tr>
<th></th>
<th>Employer #1</th>
<th>Employer #2</th>
<th>Employer #3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Company/Organization</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice setting (please choose all that apply)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your position/title</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Start Date</td>
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<td></td>
</tr>
<tr>
<td>Hours worked per week</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Hours worked providing direct patient care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name of Supervisor</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address</td>
<td></td>
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<td>Phone Number</td>
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<td></td>
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<tr>
<td>Email</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Please upload the employment verification form [here](#).

### Practice Setting

Please choose the practice settings that best describe where you provide direct individual patient care. You may choose more than one option.

This will be a drop-down menu with the following options. Applicants may choose more than one:
- Academic
- Community clinic or federally qualified health center
- Group practice
- Hospital
- Locum Tenens
- Private solo practice
- Government

### Instructions for Completing the Application

**Employer Information**

This section requests information about your current employment. For individuals that are self-employed, please note “self” on the section that asks for supervisor information. For dentists that are applying for the practice support grant, please note “self” on the section that asks for supervisor information.

**Upload:** In addition to completing this section, applicants will be required to submit an employer verification form. The employer verification form is to be completed by the applicant and employer. The applicant will be required to upload this document to the electronic application. Applicants will not be allowed to submit the employer verification form by mail and/or email. Employer verification forms received by mail will not be considered. Applications without a complete and submitted employer verification form will be considered incomplete. Applicants that are in solo practice may complete their form on their behalf and self-attest to the accuracy of the information being provided.

Full time work is considered 32 to 40 hours per week providing direct patient care for at least 45 weeks per year or as defined by your employer. Part-time work is generally considered 31 hours or less or as defined by your employer. Applicants that work less than full-time are eligible to apply. Your request for funding will be prorated based on the number of hours you provide direct patient care. For example, an applicant working 20 hours per week providing direct patient care, would be eligible for 50 percent of the up to $300,000 maximum grant.
**Practice Setting**

Please choose the practice settings that best describe where you provide direct individual patient care. You may choose more than one option. The group practice option includes Dental Service and/or Dental Support Organizations (DSO) for dental providers.

**Electronic Application – Step 5: Educational History**

**Educational History**

Please provide information regarding your educational history.

Table Employer Information

<table>
<thead>
<tr>
<th>Employer #1</th>
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<th>Employer #3</th>
</tr>
</thead>
<tbody>
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<tr>
<td>Practice setting (please choose all that apply)</td>
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<tr>
<td>Your position/title</td>
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<td>Start Date</td>
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<tr>
<td>Address</td>
<td></td>
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<tr>
<td>Phone Number</td>
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<tr>
<td>Email</td>
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</tr>
</tbody>
</table>

**Instructions for Completing the Application**

**Educational History**

Please provide information regarding your educational history. For physicians, please include information regarding your medical school and residency as well as fellowships, if applicable. For dentists, please include information regarding your dental school, internship, residency and fellowship if applicable.

**Electronic Application – Step 6: Funds Requested**

**Funds Requested**

If applying for loan repayment:
Total amount of current qualifying educational loans $__________

Amount requested: _________

Table Educational Debt (allows for up to 10 lenders)

| Lender 1 | | |
|----------|-------------|
| Name | | |
| Address | | |
| Phone Number | | |
| Account Number | | |
| Original loan amount | | |
| Current balance | | |
| Date of current balance | | |
| Status of loan | Current/Deferred/Default | | |
Please upload copies of your most recent educational loan statements. Please redact any social security information that may be contained in your student loan statements.

**If applying for a practice support grant:**

Amount requested: _________

### Instructions for Completing the Application

#### Funds Requested

This section asks for information about the funds you’re requesting.

#### Educational Loans

Qualifying educational loans are any outstanding government (federal, state or local) and commercial (i.e. private) student loan for undergraduate or graduate education obtained by the applicant for school tuition, other reasonable educational expenses, and reasonable living expenses in their pursuit of their medical and/or dental degree. Educational loans must be in the name of the applicant. Educational loans must be obtained prior to the submission of the application to the loan repayment program. Recognizing applicants may have multiple loans administered through a single loan servicer, applicants should include all loans from a single loan servicer as one lender and provide the total amount. Applicants with multiple loans through a single loan servicer should submit their most recent account statement which should include a list of each loan and their current balance.

Educational loans in pursuit of other post-graduate degrees such as a Master of Public Health (MPH), Master of Business Administration (MBA) or Doctor of Philosophy (PhD) are not eligible for the loan repayment. You may still apply if you have an MPH, MBA or PhD, however your educational loans in pursuit of those degrees are not qualifying loans eligible for a loan repayment.

The following loans do not qualify for the loan repayment program:

- Parents PLUS Loans
- Personal lines of credit
- Loans subject to cancellation
- Credit card debt
- Promissory notes

Applicant’s educational loans must be in good standing. Good standing for the purposes of educational loan debt is defined as not being in default. Applicants may have educational loans that are in deferment and/or forbearance. Awardees must continue to make payments during their terms of their contract. As part of this application, applicants will be required to submit current educational loan statements. Current lender statements are defined as dated February 1, 2019 or later. Lender statements dated prior to February 1, 2019 will not be accepted. If an applicant is awarded, they will be required to submit annual proof that their educational loans are current.

Consolidated educational loans may be eligible for consideration. Consolidated educational loans must clearly delineate the original loans and the degrees conferred. Failure to provide this information may result in ineligibility for this program.

**Upload:** Applicants will be required to submit recent educational loan statements to verify their current educational debt. Online printouts are acceptable if they include the required information. You must submit lender statements for each loan you have identified in this application. To help students with lender information and verification, the National Student Loan Data System (NSLDS) allows students to generate a summary report.
that contains originating loan information such as: outstanding balance, interest, and loan status for all of their federal loans. Applicants can visit their website for more information. https://nslds.ed.gov/npas/index.htm

Lender statements must:

☐ be dated on or after February 1, 2019
☐ include the applicant’s name, balance, account number, and lenders’ name and address
☐ match the information that is included in the application. If information is missing, the application will be considered incomplete

If you have consolidated educational loans, this consolidated refinanced loan must be from a government (federal, state, or local) or commercial lender and must include only qualifying educational loans of the applicant. Lender statement/s must clearly indicate that your loans are for educational purposes. You must submit proof of consolidation. Further, your consolidated loans cannot be with another person’s loans or with non-educational loans.

Practice Support Grants
Eligible dentists applying for a practice support grant are not required to have student loan debt. As a reminder, dentists may apply for either a loan repayment or a practice support grant. Eligible dentists may not apply for both – the electronic application will ask eligible dentists to choose the option for which they are applying. Dentists applying for the practice support grant will be required to submit a valid business plan.

**Electronic Application – Step 7: HPSA Score**

**Health Professional Shortage Area (HPSA)**
Include the HPSA or Dental HPSA score for your primary place of employment.

**Instructions for Completing the Application**

**Health Professional Shortage Area (HPSA)**
A health professional shortage area is an area designated by the federal Health Resources Services Administration (HRSA) as having a shortage of healthcare providers.

Please note whether your primary place of practice is located in a primary care HPSA (geographic area or automatic facility) – for physicians and or a dental HPSA – for dentists as defined by the federal Health Resources Services Administration (HRSA). If your geographic area HPSA score differs from your automatic facility HPSA score, please enter your highest score. Applicants will receive points based on their location. Please follow the link below to find your HPSA score. https://data.hrsa.gov/tools/shortage-area/hpsa-find

It should be noted that working in a primary care HPSA or dental HPSA is not required to participate and be eligible for the loan repayment program or practice support grant. Please check out CalHealthCares.org for more information on how to find your HPSA score.

**Electronic Application – Step 8: Patient Caseload**

**Patient Caseload**
Please provide data on your current and proposed patient population.
**Current patient population:***

<table>
<thead>
<tr>
<th>Payer</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
<td></td>
</tr>
<tr>
<td>Dual eligible (Medi-Cal and Medicare)</td>
<td></td>
</tr>
<tr>
<td>Indigent</td>
<td></td>
</tr>
<tr>
<td>Uninsured</td>
<td></td>
</tr>
<tr>
<td>Other payers</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

**Proposed patient population:***

<table>
<thead>
<tr>
<th>Payer</th>
<th>percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medi-Cal</td>
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<td></td>
</tr>
<tr>
<td>Other payers</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>100 percent</td>
</tr>
</tbody>
</table>

Please describe how you calculated your existing Medi-Cal caseload, how you and your employer will maintain your Medi-Cal caseload at 30 percent, and/or how you and your employer will increase your participation in the Medi-Cal program? (text box: with 500-word limit)

**Instructions for Completing the Application**

**Patient Caseload**

Please provide data on your current patient population or proposed patient population. If you are a dental student, resident, or fellow and don’t have a current patient caseload, please document the patient caseload of your dental school as well as physician or dental residency program or fellowship program. Also, please describe your employer or prospective employers’ patient population mix in the proposed patient population section. A caseload may be defined as annual office visits, panel of patients, payer mix, practice and/or time. The goal of this program is to support existing Medi-Cal providers to maintain and/or increase their Medi-Cal caseload as well as incentivize providers with no or low Medi-Cal beneficiaries to increase their caseload of Medi-Cal beneficiaries. Applicants will be asked to explain how they derived the 30 percent Medi-Cal caseload. This information should be considered auditable self-attestation – this means that applicants will self-attest that they will be providing a minimum of 30 percent Medi-Cal beneficiaries in their caseload. This self-attestation is subject to an audit. This information must be from a reliable and accurate source. Data may not be more than two years old.

Applicants must fill out the table listed and may be required to submit information to verify this response as well as describe how they calculated their existing Medi-Cal caseload. Medi-Cal, for purposes of this program, is any patient who is a Medi-Cal beneficiary. Dual eligible, for purposes of this program, is any patient who is a Medi-Cal and Medicare beneficiary. Indigent, for purposes of this program, is any patient who does not currently have health insurance and who is not eligible for other health care such as Medi-Cal, Medicare, or private insurance. Uninsured, for purposes of this program, is any patient who does not have health insurance. Other payers, for purposes of this program, is any patient who has any other type of payer than described above (for example: private market).
DHCS has contracted with Physicians for a Healthy California to administer CalHealthCares. (916) 551-2579
CalHealthCares.org
CalHealthCares@phcdocs.org

APPLICATION INSTRUCTIONS

Table Patient Caseload

<table>
<thead>
<tr>
<th>Payer</th>
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<tbody>
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</tr>
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<td>Other payers</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>100 percent</strong></td>
</tr>
</tbody>
</table>

The goal of this program is to support existing physicians and dentists that have 30 percent or more Medi-Cal beneficiaries as part of their caseload as well as support existing physicians and dentists to increase their participation in Medi-Cal. As such, this section requires applicants to describe their commitment to these goals.

Contractually, awardees are required to maintain a caseload with a minimum of 30 percent Medi-Cal beneficiaries. A caseload may be defined as annual office visits, panel of patients, payer mix, practice and/or time. The goal of this program is to support existing Medi-Cal providers to maintain and/or increase their Medi-Cal caseload as well as incentivize providers with no or low Medi-Cal beneficiaries to increase their caseload of Medi-Cal beneficiaries. Applicants will be asked to explain how they derived the 30 percent Medi-Cal caseload. This information should be considered auditable self-attestation—this means that applicants will self-attest that they will be providing a minimum of 30 percent Medi-Cal beneficiaries in their caseload. This self-attestation is subject to an audit.

Electronic Application – Step 9: Personal Statement

Personal Statement
Please submit a personal statement that incorporates responses to the following question. Your response should answer the question by describing your history and commitment to working with underserved communities including Medi-Cal beneficiaries, and how you will improve your patients’ health outcomes. Please note that the maximum number of words for this section is 500 words.

Describe your experience working with underserved communities and how you as a provider will improve the health outcomes of that patient population.

Instructions for Completing the Application

Personal Statement
Applicants will be required to provide a personal statement that narrates their experience working with underserved communities and how they will improve outcomes for that patient population. The goal of this program is to support existing physicians and dentists that have 30 percent or more Medi-Cal beneficiaries as part of their caseload as well as support existing physicians and dentists to increase their participation in Medi-Cal. As such, this section requires applicants to describe their commitment to these goals.

Electronic Application – Step 9: Only for Students/Practice Support Grant

For current students, residents, fellows and interns only:
Letters of Recommendation
Please include a letter of recommendation from your program. The letter should speak to your commitment to serving California’s underserved communities, and Medi-Cal beneficiaries in particular.

For dentists applying for practice support grant:
Please select the county you are proposing to relocate to in your business plan.
DHCS has contracted with Physicians for a Healthy California to administer CalHealthCares.

(916) 551-2579
CalHealthCares.org
CalHealthCares@phcdocs.org

APPLICATION INSTRUCTIONS

Please select the county you are proposing to relocate to in your business plan:

- Alpine
- Amador
- Calaveras
- Yuba
- Inyo
- Trinity
- Mariposa
- Mono
- Sierra
- Modoc
- Glenn
- Del Norte
- Colusa
- Lassen
- Humboldt
- Kings
- Monterey
- Other

Valid Business Plan
Please submit a valid business plan documenting your plans for relocating your practice to a high-needs region.

Instructions for Completing the Application

Letters of Recommendation
Applicants are required to submit a letter from their Program Director or current clinical supervisor if they are a dental student as well as a physician or dental resident and/or fellow. This letter should speak to the applicant's commitment to serving California's underserved communities, and especially Medi-Cal beneficiaries as well as why explain why the applicant is a good candidate for the program.

The letter from the applicant's current employer or current clinical supervisor should:
- be on letterhead
- include an original signature
- be dated within one year of the application submission (example: letters with a date older than April 26, 2018 will not be considered)

Practice Support Grant:
Please submit a valid business plan documenting your plans for relocating your practice to a high needs region. Your business plan should include detailed information regarding your existing practice, your prospective practice, proposed location and plans to meet the requirement of a minimum of 30 percent direct patient caseload serving Medi-Cal beneficiaries. See separate document (insert hyperlink) with more detail on valid business plan.
<table>
<thead>
<tr>
<th><strong>Electronic Application – Step 10: Attestations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attestations</strong></td>
</tr>
<tr>
<td>You <strong>must</strong> check all boxes to be considered eligible to apply:</td>
</tr>
<tr>
<td>I certify that I am the applicant noted in the application and I am the one submitting this application.</td>
</tr>
<tr>
<td>I attest that the statements herein are true and complete to the best of my knowledge. I understand that knowingly submitting false information will void this application and may be considered breach of contract.</td>
</tr>
<tr>
<td>I attest that I am eligible to work in the United States for the terms of the contract.</td>
</tr>
<tr>
<td>I attest that I will not be participating in another loan repayment program as of July 1, 2019.</td>
</tr>
<tr>
<td>I acknowledge that these funds are subject to an audit pursuant to Article 2.5 (commencing with Section 30130.50), Chapter 2 of Division 2 of the Revenue and Taxation Code.</td>
</tr>
<tr>
<td>I attest that I do not have a judgement lien against my property for a debt to the United States.</td>
</tr>
<tr>
<td>I attest that I do not have a history of failing to comply with or inability to comply with service or payment obligations.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Instructions for Completing the Application</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attestations</strong></td>
</tr>
<tr>
<td>The applicant will be asked to attest to the following statements:</td>
</tr>
<tr>
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</tr>
<tr>
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</tr>
<tr>
<td>I attest that I am eligible to work in the United States for the terms of the contract.</td>
</tr>
<tr>
<td>I attest that I am not currently participating in another state or federal loan repayment program as of July 1, 2019.</td>
</tr>
<tr>
<td>I acknowledge that these funds are subject to an audit pursuant to Article 2.5 (commencing with Section 30130.50), Chapter 2 of Division 2 of the Revenue and Taxation Code.</td>
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<tr>
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<td>Please note that knowingly providing inaccurate information voids this application and may be considered breach of contract.</td>
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<table>
<thead>
<tr>
<th><strong>Electronic Application – Step 11: Program Requirements</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Program Requirements</strong></td>
</tr>
<tr>
<td>You must check all boxes to be considered eligible to apply:</td>
</tr>
</tbody>
</table>
DHCS has contracted with Physicians for a Healthy California to administer CalHealthCares.

for physicians
I commit to providing direct patient care – with a minimum of 30 percent of my individual direct parent care being Medi-Cal beneficiaries – for the next five years.

for dentists applying for LRP
I commit to providing direct patient care – with a minimum of 30 percent of my individual direct parent care being Medi-Cal beneficiaries – for the next five years.

for dentists applying for the practice support grant
If applying for the practice support grant, I commit to providing direct patient care with a minimum of 30 percent of my individual direct parent care being Medi-Cal beneficiaries for the next ten years.

(for all)
I will have a current and non-restricted license to practice in the state of California by the start of the contract and during the terms of the contract.

I commit to being a Medi-Cal provider in good standing without existing suspensions, disbarments or revocations.

I will make payments and stay current and in good standing with my educational loans.

I will provide semi-annual and annual information to verify that I am meeting the terms of the program.

By submitting this application, I agree to all the conditions stipulated in the loan repayment program description.

I agree to provide updated information to PHC immediately and no less than three business days – for example but not limited to change in contact information, place of employment and/or employment status.

I acknowledge that if I am awarded, this is subject to public information.

Instructions for Completing the Application

Program Requirements
This section provides more detailed information on the program requirements. Applicants are required to check the box below for the application to be considered complete.

Electronic Application – Step 12: Permissions

Permissions
I consent to the release - to Physicians for a Healthy California and the Department of Health Care Services - of information about me to the extent that it bears upon any of the following: my education; internship, postgraduate, preceptorship, or residency specialty training; board certification; experience; professional conduct; ethics; ability to work with others; hospital and other affiliations; disciplinary actions; malpractice claims history; litigation experience; state licensure; and controlled substance licensure. I intend that this consent includes all information that reflects on my ability to safely, competently, and professionally perform the professional activities required of me should I receive a contract under this program. I agree that this consent extends to all persons, institutions, and entities that have such information about me including: colleges, universities, professional societies, hospitals, specialty boards, practice groups, clinics, insurance companies, partnerships, professional corporations, and employers, and to persons and committees associated with any of these. I also give my consent for all such persons, institutions, and entities to express their evaluation of me and make recommendations about my professional skill, conduct, and ability to perform clinical duties in the area for which I have applied.
I agree to provide permission to my employer to release information regarding my work hours, and related information pertinent to the loan repayment program.

I agree to provide permission to my student loan lenders to release information regarding my loans’ status and balances, and related information pertinent to the loan repayment program.

I agree (Applicant must check in order to submit application)

Instructions for Completing the Application

Permissions
This section provides information regarding permissions to verify the accuracy of the application submitted. Applicants are required to check the box below for the application to be considered complete.

Electronic Application – Application Submission

Thank You
Thank you for applying to the CalHealthCares program. We appreciate your commitment to serving California's underserved communities and in particular, Medi-Cal beneficiaries.

Please note that that once you submit the application, you will not be able to make changes to the application. Please ensure that your application is complete and accurate to the best of your ability. If you would like to add additional information or make edits to your application, please submit them electronically to CalHealthCares@phcdocs.org before the application deadline. Supplemental information received after the deadline of April 26, 2019 at 11:59PM will not be considered.

The Department of Health Care Services and PHC expect to make funding announcements by June 30, 2019. Awardees will be notified by email and mail. Awardee information may also be posted on PHC’s website and other public information sources. Awardees will be required to submit their acceptance to this program by submitting a signed contract within seven business days. Please keep checking our website at www.CalHealthCares.org for up to date information.

Instructions for Completing the Application

No action needed from the applicant.

Review and Selection Process
The CalHealthCares Advisory Council established a fair and impartial process for scoring and evaluating applications. Each application will be reviewed by the Advisory Council and PHC staff to assess their eligibility against the criteria. Scoring criteria is included as an attachment. Applying is not a guarantee of funding. The Advisory Council will make recommendations to DHCS. DHCS will have the final authority in terms of who gets funded. Funding is prioritized based on the criteria set forth in Welfare and Institutions Code 14114.

DHCS and PHC expect to make funding announcements by June 30, 2019. Awardees will be notified by email and mail. Please ensure that your contact information is complete and accurate. Awardee information may be posted on DHCS and PHC’s website. Awardees will be required to submit their acceptance to this program by submitting a signed contract within seven business days. Please keep checking our website at www.CalHealthCares.org for up to date information.
Thank You
Thank you for applying to the CalHealthCares program. We appreciate your commitment to serving California's underserved communities and in particular, Medi-Cal beneficiaries.