HEALTH PROFESSIONS
EDUCATION FOUNDATION
Giving Golden Opportunities

Licensed Mental Health Service Provider Education Program

Loan Repayment Application

Spring Postmark Deadline: March 24, 2009

Increasing the supply of mental health professionals practicing in mental health professional shortage areas

Improving access to mental healthcare in rural and urban areas of California

Awarding mental health professionals who provide direct patient care in Mental Health Professional Shortage Areas, the Public Mental Health System, publicly funded or public mental health facilities, or non-profit private mental health facilities in underserved communities

Application Instructions

If you want receipt confirmation of your application packet, please submit one self-addressed stamped envelope with your application.

You must be a California resident and a citizen or permanent resident of the U.S. to apply.

The Health Professions Education Foundation (Foundation) recognizes the need for improving conditions which lead to mental healthcare disparities in the state, including those disparities arising from cultural and linguistic barriers. At the same time, the Foundation acknowledges the difficulty of many culturally or linguistically competent mental health service providers to practice in mental health professional shortage areas because of the heavy debt load related to a career as a licensed mental health service provider. The Licensed Mental Health Service Provider Education Program encourages mental health service providers to practice in a mental health professional shortage area or qualified facility in California by authorizing a plan for repayment of their educational loans in exchange for their service in a designated shortage area for a minimum of two (2) years.

The Licensed Mental Health Service Provider Education Program repays up to $15,000 in outstanding government or commercial educational loans for expenses incurred for a mental health service provider education.

Loan repayment recipients will be required to sign a written contract with the Foundation outlining the provisions which must be met to fulfill the obligations under this program. Failure to comply with the terms of the contract may result in the awardee's repayment of funds awarded plus interest.

QUALIFIED FACILITIES

When submitting an application, the applicant may already be working at, or must have entered into a written agreement to provide services under this program with a qualified facility.

Qualified facilities are defined as one of the following:

(1) "Mental Health Professional Shortage Area" (MHPSA) means an area designated as such by the U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions' Shortage Designation Branch.

(2) "Public Mental Health System" means publicly-funded mental health programs/services and entities that are administered, in whole or part, by the Department of Mental Health or the County. It does not inlcude programs and/or services administered, in whole or part, by federal, state, county or private correctional entities or programs and/or services provided in correctional facilities.

(3) "A publicly funded facility," which means a health facility, as defined by Health and Safety Code Sections 1200, 1200.1, and 1250, conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city.

(4) "A publicly funded or public mental health facility," which means a hospital, clinic, or long-term care facility licensed and/or certified by the California Department of Mental Health and/or the California Department of Health Care Services that is conducted, maintained, or operated by this state or by any of its political subdivisions or districts, or by any city, and that provides mental health services.

(5) "A non-profit private mental health facility," which means a hospital, clinic, or long-term care facility licensed and/or certified by the California Department of Mental Health and/or the California Department of Health Care Services that is operated by a non-profit entity that contracts with a county mental health entity or facility to provide mental health services.

If a program participant is paid, the facility must pay prevailing wages to the program participant. Facilities must agree not to use the program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

LOAN REPAYMENT AWARDS

The Foundation, under the Licensed Mental Health Service Provider Education Program, is authorized to repay outstanding government and commercial educational loans for expenses related to the recipient's education required to practice as a mental health service provider (i.e., principal, interest, and related expenses for tuition, and educational expenses). Award recipients are responsible for making continued loan payments during the course of their participation in this program.

Loan repayment awards of up to $15,000 are available to the program participants as an educational loan repayment. In no event shall the cumulative amount of the educational loan repayments exceed the amount of the participant's outstanding educational loan balances as of the date the written contract is signed between the Foundation and the award recipient.

LOAN REPAYMENT ELIGIBILITY

"Licensed mental health service provider" means a psychologist licensed by the Board of Psychology; registered psychologist; postdoctoral psychological assistant; postdoctoral psychology trainee employed in an exempt setting pursuant to Section 2910 of the Business and Professions Code, or employed pursuant to a Department of Mental Health waiver pursuant to Section 5751.2 of the Welfare and Institutions Code; licensed marriage and family therapist; marriage and family therapist intern; licensed clinical social worker; associate clinical social worker; licensed psychiatrist, registered psychiatrist, licensed psychiatric mental health nurse practitioner, and registered mental health nurse practitioner.

Mental health service providers awarded under this program must complete a two (2) year service obligation to practice as a full-time mental health profession in a MHPSA or qualified facility of California providing direct patient care. "Full-time" means a regular work week of not less than 32 hours. "Direct patient care" means the provision of healthcare services directly to individuals being treated for, or suspected of having, physical or mental illness. Direct patient care includes preventative care. The first line supervision of direct patient care shall be considered "direct patient care."

An applicant who has signed a contract or written agreement with another entity to practice their mental health profession in exchange for financial assistance, including tuition reimbursement, scholarship, loans, or loan repayment, shall be ineligible to receive a loan repayment until the obligation to this other entity has been fulfilled.

Awardees may reapply for an additional loan repayment award at the completion of their two (2) year service obligation. Awardees shall not be awarded more than two (2) contracts.

Application Instructions (cont.)

SELECTION CRITERIA

The most qualified applicants will be selected in the areas of California with the greatest workforce need. Priority consideration will be given to those applicants best suited to meet the cultural and linguistic needs and demands of consumers, based on the applicant meeting one or more of the following criteria:

- **Work Experience** – mental health related work experience in a MHPSA or qualified facility and have received significant training in cultural and linguistic competence.
- **Cultural and Linguistic Competence** – applicants ability to understand and respond effectively to the cultural and linguistic needs brought by consumers to mental healthcare encounters.
- **Career Goals** - professional goals for the next five (5) to ten (10) years.
- **Community Service** - volunteer and/or professional service in the community.
- **Community Background** - family structure, socio-economic background, and community where the applicant grew up.
- **Fluency** - fluency in a language other than English must be verified on the Employment or Volunteer Verification Form.

Priority will be given to those applicants whose community background and commitment indicates the likelihood of long-term employment in a qualified facility or MHPSA even after the service obligation has ended and who have completed significant training in cultural and linguistic competence.

Awards are made on a competitive basis. Each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. Only complete applications will be evaluated. The Foundation may not notify individuals if their application is incomplete.

SUBMIT THE FOLLOWING

1. Completed Application

Complete both pages of this application. It must be completed, signed, and dated to be considered eligible.

2. Personal Statement

Questions can be found on page two (2) of this application, please provide a comprehensive response to each question. Your statement must be typed and no more than two (2) pages total. Restate and number each question along with your answer.

3. Employment or Volunteer Verification Form

This form must be signed by a supervisor or administrative officer who can verify the applicant's hours. The Employment or Volunteer Verification Form is enclosed as part of the application.

4. Educational Debt Reporting Form

Submit the attached educational debt reporting form. If any information is not filled in, the application will be considered incomplete.

5. Lender Statements

Attach copies of your most recent lender statements (no more than six (6) months old) with your name, the name of lender, balance owed, account number, and monthly payments.

6. Two Professional Letters of Recommendation

Letters of recommendation must be dated within the last six (6) months of the application deadline and must be from an organization/entity for which the applicant has provided services. The letters must be on letterhead or include the author's title, name of employer, mailing address, contact information, and relationship to applicant.

7. Proof of Registration or Licensure

A copy of a document which includes a license number, registration number, or unique identification number issued by one of the following: the Medical Board of California, California Board of Behavioral Sciences, California Board of Psychology, or the California Board of Registered Nursing.

APPLICATION SUBMISSION

Applications must be postmarked by the deadline. In order to be reviewed, each part of the application must be completed. All supporting documentation must be submitted by the appropriate deadline. The Foundation may not notify applicants if their applications are received incomplete.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the final filing date. Applicants are urged to contact the Foundation prior to the final filing date to verify if their application was receive complete.

SPRING POSTMARK DEADLINE: MARCH 24, 2009

Submit applications to:

Health Professions Education Foundation
Licensed Mental Health Service Provider Education Program
400 R Street, Room 460
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

Application

Last Name _____, First Name _____

LMH

Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

Please enter the amount you are requesting (up to $15,000): _____

PART A - PERSONAL INFORMATION

(Please type or print your answers legibly in the space provided.)

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr.	Last Name:	First Name:	Middle Initial:
CA Drivers License Number:		*Social Security Number:	
Mailing Address:			
City:		State:	Zip Code
County:			
Permanent Address (if different than above):			
City:		State:	Zip Code:
County:			
Home Phone: ( )		Date of Birth:	
Cell Phone: ( )		E-mail Address:	
Work Phone: ( )		Gender: ☐ Male ☐ Female	

Are you a citizen or permanent resident of the U.S.? ☐ Yes ☐ No Are you a California resident? ☐ Yes ☐ No

Which CA Board are you registered or licensed with? ☐ Behavioral Science ☐ Psychology ☐ Medical Board ☐ Registered Nursing

License or Registration #: _____

What is your mental health profession?

☐ Licensed Marriage & Family Therapist ☐ Marriage & Family Therapist Intern

☐ Licensed Psychiatrist ☐ Registered Psychiatrist ☐ Licensed Clinical Social Worker ☐ Associate Clinical Social Worker

☐ Licensed Psychiatric Mental Health Nurse Practitioner ☐ Registered Psychiatric Mental Health Nurse Practitioner

☐ Licensed Psychologist ☐ Registered Psychologist ☐ Postdoctoral Psychological Assistant ☐ Postdoctoral Psychological Trainee

Which best describes your ethnic background? (optional):

☐ African American ☐ Caucasian ☐ Asian American ☐ Native American

☐ Pacific Islander ☐ Hispanic/Latino ☐ Other (Please specify) _____

PERSONAL INFORMATION NOTIFICATION

The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 16 of Title 22 of the California Code of Regulations, Sections 97900 et seq.) require every individual to furnish appropriate information for application to the Licensed Mental Health Service Provider Education Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the return of the application as incomplete. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Program Director, Health Professions Education Foundation, 400 R Street, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

Application (cont.)

Applicant's Name: _____

PART B – WORK EXPERIENCE

1. How many years have you worked in a qualified facility or an MHPSA? _____ years

2. Do you currently provide direct patient care in or through a qualified facility or MHPSA?

❒ Yes ❒ No

PART C – COMMUNITY BACKGROUND

1. Do you come from an economically disadvantaged background (i.e. low-income or subsidized income from local, county, state, and/or federal agencies)?

❒ Yes ❒ No

PART D – FLUENCY

1. List any languages in which you are fluent. This must also be verified by the applicant's employer on the Employment or Volunteer Verification Form.

1st language: _____

2nd language: _____

3rd language: _____

PART E – PERSONAL STATEMENT

Your statements must be typed and no more than two (2) pages total. Restate and number each question along with your answer.

1. Why do you want to participate in the Licensed Mental Health Service Provider Education Program?
2. Describe/explain your interest in working in an underserved community.
3. Describe how your upbringing and/or training have prepared you to understand and respond effectively to the cultural and linguistic needs of mental health consumers?
4. Describe any community service or professional organizations which you have for the past two (2) years been involved with, outside of your internship hours. Please include a description of your role and the length of time you have been committed to these groups.
5. What are your professional goals for the next five (5) to ten (10) years, as they relate to a mental health profession?
6. Please add any other information you believe is relevant.

PART F – QUESTIONNAIRE

1. Are you a previous awardee of the Foundation? ❒ Yes ❒ No
   If yes, please enter the contract # _____

2. Do you currently owe a service obligation to another entity? ❒ Yes ❒ No

   "Service Obligation" means the contractual obligation agreed to by the recipient of a loan repayment where the recipient agrees to practice their profession for a specified period of time in or through a designated facility.

3. How did you hear about the Licensed Mental Health Service Provider Education Program? (Check all that apply)

❒ Work (employer or co-worker) ❒ Friend/Acquaintance
❒ TV ❒ Radio ❒ Foundation Website
❒ Other Website ❒ Advertisement
❒ Newspaper or Publication (please specify) _____
❒ Organization or Affiliation (please specify) _____
❒ Other source (please specify) _____

4. How did you receive the Licensed Mental Health Service Provider Education Program application? (Check only one)

❒ Program Director/Instructor ❒ Foundation Office
❒ Foundation Website ❒ Other Website
❒ Work (employer/co-worker) ❒ Friend/Acquaintance
❒ Other (please specify) _____

PART G – 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 contract with a practice setting committing to a minimum two (2) years of full-time practice in a mental health professional shortage area. I authorize the Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application. I understand that once submitted my application and supporting documents become the rights of the Foundation. I also understand that my personal statement becomes the property of the Foundation and may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

Last Name: _____

First Name: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

SUBMISSION CHECKLIST

- ❒ **1. Completed Application**
- ❒ **2. Employment and Volunteer Verification Form**
- ❒ **3. Educational Debt Reporting Form**
- ❒ **4. Lender Statements**
- ❒ **5. Personal Statement**
- ❒ **6. Two (2) Professional Letters of Recommendation**
- ❒ **7. Proof of Licensure or Registration**

Employment or Volunteer Verification Form

This form must be completed by a supervisor or administrative officer who can verify the applicant's hours. The person signing this form may not be related to the applicant by blood, marriage, or adoption.

Applicant's Name:_____

Job Title: _____

On a weekly basis, how much time (average amount of hours) does the applicant spend providing the following services:

Face-to-face interaction: _____ Administration: _____ Supervision, management, or training: _____

❒ Employment or ❒ Volunteer Average Monthly Hours Worked _____ ❒ F/T or ❒ P/T Start Date: ____/____/____

Facility Name: _____

Address (NO P.O. BOXES): _____

City: _____ State: _____ Zip Code: _____

County: _____

I can verify that the applicant can fluently speak the following language(s):

1st language: _____

2nd language: _____

3rd language: _____

I certify that the facility will pay the applicant (if in a paid capacity) prevailing wages and that I agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.). I certify that I am the supervisor or administrative officer at this facility, which meets the criteria of a qualified facility. Definitions for the qualified facilities listed below can be found in the instructions section of this application under "Qualified Facilities". Please contact the Health Professions Education staff if you need asssistance in determining whether or not your facility will qualify. This information will be verified with the Health Professions Education Foundation. Please check all that apply:

❑ Mental Health Professional Shortage Area

❑ Public Mental Health System

❑ A non-profit private mental health faciliity

❑ A publicly funded facility

❑ A publicly funded or public mental health facility

Name: (Please Print)_____

Signature: _____

Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____

Attach Business Card Here

Educational Debt Reporting Form

All spaces must be completed. If any information is missing the application will be considered incomplete. You must submit current lender statements (dated within six (6) months of the application deadline) for the educational debt listed below. They should include your name, the name of the lender, balance owed, accont number and monthly payments.

LOAN 1

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

LOAN 2

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

LOAN 3

School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

LOAN 4

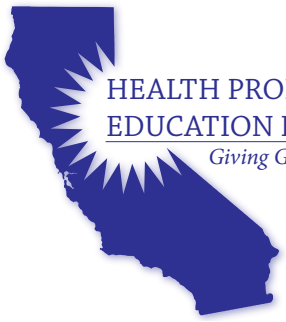
School Attended: _____ Loan Period (Start Date): ___/___/___ (End Date): ___/___/___

Loan Program: _____ Loan ID#: _____ Lending Institution: _____

Lender's Address: _____

City: _____ State: _____ Zip Code: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____



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Revised 12-3-2008