Alaska's SHARP Program

Instructions for submitting SHARP-I Carryover - Behavioral Health Specific Solicitation practitioner application

The SHARP-I application is divided into two sections:

Section I: Practitioner application and loan information
Section II: Site application

Information you'll need:

- Education information
- Licensure information
- Current employer information, if applicable
- Loan and lender information
- Past employer information

Instructions:

Section I (Practitioner application and loan information) has three components:

1. **Fillable .pdf form** - Fill in the .pdf application form electronically and save your information using the free Adobe Reader software. Do not print and scan the form.
2. **Loan verification form** – Fill out top portion (page 9 of .pdf), print, give to lender or loan servicing agency to fill and return to you, and scan (a completed form for each lender)
3. **Signature page** – Print, sign, and scan (last page of .pdf).

Attach the three completed attachments to a single email with the subject line: "SHARP Application [Last Name]" to robert.sewell@alaska.gov before 5:00 p.m. Alaska Time on September 8, 2016.

No application is complete until **both** Sections I and II are completed and submitted. Final award agreement is dependent on established job opportunity and full licensure.

Please refer to complete program guidelines and definitions of terms available at http://dhss.alaska.gov/dph/HealthPlanning/Pages/sharp/ or click the **?** in the application.

For any questions about SHARP, and/or about this form, or to request an alternate application format, please contact:
Robert Sewell, PhD, SHARP Program Manager
907-465-4065 (9:00-5:00 Alaska Time)
robert.sewell@alaska.gov

Note to applicants:

Both practitioners and sites are welcome to independently submit their respective sections to indicate their interest in participation. Further, both "clinicians-without-employers" (i.e. new recruits) and "employers-seeking-clinicians" (as yet to be identified) are welcome to apply. In this process, both parties may find suitable match-ups.

A Memorandum of Agreement (Service Contract) will be executed between the practitioner, his/her employer and the State of Alaska, and will require a 75% match payment by the employer for Tier-1 positions and a 25% match payment by the employer for Tier-2 positions. Practice sites must meet eligibility criteria described on the SHARP website. A particular site/employer may wish to prioritize and/or limit the number of candidates it will support under this program.

Application Deadline: 5:00 p.m. Alaska Time, September 8, 2016

Part A (1) – Personal Information

Age and Race information is requested to help Alaska DHSS monitor workforce diversity.

First name	
Middle name	
Last name	
Other names used *(list any other names that you have used in your educational or professional life)*	
Sex	
Date of birth	
☐ **American citizen** ☐ **Permanent resident**	
Mailing address	
City	
State	
ZIP	
Country	
Home phone	
Cell phone	
Work phone	
Other contact phone	
Home e-mail	
Work e-mail	
Race *(check all races with which you identify)*	☐ American Indian, Alaska Native, Eskimo or Aleut ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Black or African American ☐ White ☐ Some Other Race(s)
Are you multi-racial? *For this question, you are multi-racial if you have parents from more than one of the broad race categories listed or if at least one of your parents is multi-racial.*	☐ Yes ☐ No
Hispanic ethnicity	☐ Yes ☐ No

If your answers to this section need further detail, please write your comments here:

Part A (1) – Education and Professional Information

Professional designation	☐ Physician ☐ Dentist ☐ Pharmacist ☐ Dental Hygienist ☐ Physician Assistant ☐ Nurse Practitioner ☐ Nurse Midwife ☐ Nurse (RN) ☐ Psychologist ☐ Clinical Social Worker ☐ Licensed Professional Counselor ☐ Marriage and Family Therapist
Specialty and/or other credentials	
Years worked as a licensed practitioner in THIS occupation	**Year practice began**
Licensed occupation	☐ Doctor of Allopathic Medicine (M.D.) ☐ Doctor of Osteopathic Medicine (D.O.) ☐ Dentist (D.D.S. or D.M.D) ☐ Pharmacist ☐ Nurse Practitioner ☐ Physician Assistant ☐ Dental Hygienist (RDH) ☐ Registered Nurse (RN) ☐ Nurse Midwife ☐ Clinical or Counseling Psychologist (Ph.D. or Psy.D.) ☐ Clinical Social Worker (LCSW) ☐ Licensed Professional Counselor ☐ Marriage and Family Therapist
State (or country)	
License No.	
Full license date	
Are you exempt from Alaska licensure?	☐ Yes ☐ No *If yes, reason:*

List your school, post-graduate or professional program, and residency program (if applicable), and graduation or completion date of the degree required for your employment.

a) **School, program, or residency name**	
State (or country):	
Graduation or completion date	
b) **School, program, or residency name**	
State (or country)	
Graduation or completion date	
c) **School, program, or residency name**	
State (or country)	
Graduation or completion date	

If your answers to this section need further detail, please write your comments here:

Part A (2) – SHARP Support and Service Obligation	
What level of SHARP support are you requesting?	◯ Full-time ◯ Half-time ?
Are you applying to SHARP for a position into which you are already hired?	◯ Yes ◯ No
If yes:	
Position title	
Does this position have administrative duties (e.g. management, supervision)?	◯ Yes ◯ No ◯ Don't Know
If "Yes", then what portion of your position involves administrative duties?	% ?
Is this job a direct patient care position?	◯ Yes ◯ No
If "Yes", then what portion of your position involves direct patient care duties?	% ?
Is this job a primary care position?	◯ Yes ◯ No
If "Yes", then what portion of your position involves delivery of primary care?	% ?
Do you currently have or anticipate having another service obligation with any other entity?	◯ Yes ◯ No
Check ANY other service obligation(s) that you have or anticipate having:	☐ National Health Services Corps Loan Repayment ☐ National Health Services Corps Scholars Program ☐ WWAMI Medical School tuition service obligation ☐ USPHS Commissioned Officer Corps ☐ Employer-provided sign-on bonus service obligation ☐ Employer-provided moving expense service obligation ☐ Indian Health Service Loan Repayment Program ☐ Nurse Education Loan Repayment Program (aka NURSE Corps LRP) ☐ Active Military ☐ National Guard ☐ Reserve Military ☐ Private Foundation, specify: ☐ Other, specify:
When does your service obligation end?	
Do you here attest that during the entire potential SHARP Service Contract (MOA) period you will not have or accept any other service obligation?	◯ Yes ◯ No
If your answers to this section need further detail, please write your comments here:	

Part A (3) – Practice Site (Already-hired applicants only)

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Practice site 1		
Site name		
Sponsoring agency		
Address line 1		
Address line 2		
City		
State		
Zip		
Work phone		
Work email		
Site representative (person) or employer contact, if known:		
Name		
Phone		
Email		
Employment date		◯ Actual ◯ Expected
Hours per week		◯ Actual ◯ Expected
Site type: *Check ALL of the following that describe this practice site.*	☐ Certified Rural Health Clinic (CRHC) ☐ Community Health Center (Sec 300 CHC) or "Look-Alike" ☐ Community Mental Health Clinic (CMHC) ☐ Critical Access Hospital ☐ Public Clinic (operated by state or local government) ☐ Private Not-for-Profit Clinic ☐ Tribal-Managed Health Facility ☐ Hospital ☐ Hospital-Affiliated Clinic ☐ Local Health Department ☐ Long-Term Care Facility ☐ Prison (Adult Corrections) ☐ Prison (Juvenile Justice Detention or Treatment) ☐ State Psychiatric Hospital ☐ Other, specify:	

If your answers to this section need further detail, please write your comments here:

Part A (3) – Practice Site (Already-hired applicants only)

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Practice site 2			
Site name			
Sponsoring agency			
Address line 1			
Address line 2			
City			
State			
Zip			
Work phone			
Work email			
Site representative (person) or employer contact, if known:			
Name			
Phone			
Email			
Employment date		◯ Actual	◯ Expected
Hours per week		◯ Actual	◯ Expected
Site type: *Check ALL of the following that describe this practice site.*	☐ Certified Rural Health Clinic (CRHC) ☐ Community Health Center (Sec 300 CHC) or "Look-Alike" ☐ Community Mental Health Clinic (CMHC) ☐ Critical Access Hospital ☐ Public Clinic (operated by state or local government) ☐ Private Not-for-Profit Clinic ☐ Tribal-Managed Health Facility ☐ Hospital ☐ Hospital-Affiliated Clinic ☐ Local Health Department ☐ Long-Term Care Facility ☐ Prison (Adult Corrections) ☐ Prison (Juvenile Justice Detention or Treatment) ☐ State Psychiatric Hospital ☐ Other, specify:		

If your answers to this section need further detail, please write your comments here:

Part A (3) – Practice Site **(if you are still searching for a job)**

Complete the information requested below for each practice site at which you intend to fulfill your SHARP service obligation. A practice site is a location at which you will provide medical, dental or behavioral health services to residents of a Health Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site. If additional pages are required, attach a copy.

Indicate practice site(s) of interest, if known:	
Site name	
Sponsoring agency	
Address line 1	
Address line 2	
City	
State	
Zip	
Work phone	
Work email	
Site representative (person) or employer contact if known:	
Name	
Phone	
Email	
The employment date and hours of potential interest to you:	
Employment date	
Hours per week	
Site type: *Check **any** of the following that describe the type of practice site you are interested in.*	☐ Certified Rural Health Clinic (CRHC) ☐ Community Health Center (Sec 300 CHC) or "Look-Alike" ☐ Community Mental Health Clinic (CMHC) ☐ Critical Access Hospital ☐ Public Clinic (operated by state or local government) ☐ Private Not-for-Profit Clinic ☐ Tribal-Managed Health Facility ☐ Hospital ☐ Hospital-Affiliated Clinic ☐ Local Health Department ☐ Long-Term Care Facility ☐ Prison (Adult Corrections) ☐ Prison (Juvenile Justice Detention or Treatment) ☐ State Psychiatric Hospital ☐ Other, specify:
Location type: *Indicate **any** practice location you would be interested in*	☐ Urban ☐ Rural ☐ Remote ☐ Any

If your answers to this section need further detail, please tell us more about your potential practice site interests:

Part B – Loan Information

- You must list all educational loans or conditional service agreements for which you have a remaining balance whether or not they entail a service obligation.
- Include only those loans incurred to finance your undergraduate or graduate education and training that led to the professional degree necessary for the position through which you will fulfill your SHARP service obligation.
- If you have consolidated or refinanced any eligible loan with a non-educational loan, no portion of the consolidated/refinanced loan is eligible for loan repayment and must not be listed below or included in your practitioner application lender verifications.
- Please list the information about all of your current education loans/service obligations in the Current Loans section.
- List all original educational loans that have been consolidated into one of your current loans in the Original Loans That Have Been Consolidated section.
- For each education loan that you want considered for SHARP repayment, you must attach a completed *Part B (2) Loan Lender/Holder Information* form. A form is complete when the top portion has been filled out and signed by you, and the bottom portion has been filled out and signed by the lender/holder of the loan(s).
- Steps to complete the *Part B (2) Loan Lender/Holder Information* form:
  1. Complete the top portion of the form. Make sure your name on the form matches your name on the loan documents. If you use a different name here, be sure to enter it in the "Other Names Used" field in Part A (1) - Personal.
  2. Print the form(s), sign and date the printed form(s).
  3. Organizations may list up to four loans in the table provided. If a single holder holds more than four loans, you must send additional copies so that all the loans can be listed in the table provided.
  4. Mail or fax the form(s) to each organization that holds one or more of your loans. You must ask them to complete Section II and then email the form(s) as an attachment back to you.
  5. Repeat for each lending organization that holds one or more of your loans.
  6. Be sure that the information you entered in the Part B (1) - Current Loans section matches the information on the returned form.
  7. Do not submit your application until you have attached all of the necessary completed lender forms.

Part B (1) - Current Loans *(copy additional pages as necessary)*

Account or ID number	Academic period (Start-End)		Name of Loan Program	Lender	Balance	Loan entails a service obligation	This a consolidation loan
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
						Yes No	Yes No
				Total educational loan debt (this page):	0		

Original loans that have been consolidated

For each loan marked as consolidated above, enter each Original Loan Name. If you are unable to provide the original loan names, enter Not Available in the Original Loan Name column.

Current Loan Account or ID Number	Original Loan Names (separate names with commas)

If your answers to this section need further detail, please write your comments here:

Alaska's SHARP Program - Part B (2) Loan Lender/Holder Information Form

On this form, the "lender" refers to the original lender, whereas the "holder" is an entity that has subsequently assumed the promissory note- such as in the case of consolidation of loans. For loans to qualify for repayment, they must have been made to the borrower named in Section I for the purpose of obtaining medical or graduate level education in a health care field or undergraduate coursework leading to their graduate work. All other non-school loans or ineligible school loans must be excluded from reporting on this form. More information can be found here

To the Holder of Notes: The borrower identified in Section I may qualify for loan repayment by the State of Alaska under provisions of Alaska's SHARP program. Complete Section II with the most recent and accurate information regarding the borrower's educational loans (described below). You may list up to four loans in the table included in Section II. If necessary, fill out additional copies of the Part B(2) application.

SECTION I - TO BE COMPLETED BY BORROWER

Last Name		First Name		Middle Name	
Address		City		State	Zip
Home Phone		Fax		Email	
Cell Phone		Academic Period Covered by Loans			
Lender Name			Holder Name		
Lender Address			Holder Address		
City	State	Zip	City	State	Zip
By my signature, I authorize the holder of the promissory note(s) of my student loan/service obligation(s) to release information about my student loan/obligation(s) to the Alaska Department of Health & Social Services for the purposes of qualifying the loan(s) for repayment by the State of Alaska.				Borrower Signature	Date

SECTION II - TO BE COMPLETED BY HOLDER OF NOTES

LENDER/Holder Name			Contact Name	
LENDER/Holder Address			Contact Address	
City	State	Zip	Contact Email	

Account #	Note Date	Name on Loan Program	Lender	Balance	Days Past Due	Remaining Payments (#)	Monthly Payment

Do any of the loans entail a service obligation? Yes No		If yes, which ones:	
LENDER/Holder E.I.N. #:	** Holder of Notes: Email this completed form as an attachment to Borrower*		
I certify that the information provided in Section II is true and correct.	Typed or Printed Name of Authorized Official	Signature of Authorized Official	Date

Part C – Experience

Present chronology of directly relevant health care practitioner work experience

Position title #1	
Name of practice/agency	
Position dates	
Position total years	
Clinical or admin. supervisor	
Supervisor email	
Supervisor phone	
Occupation (discipline)	

Site type (*check ALL of the following that apply):*

- ☐ Certified Rural Health Clinic (CRHC)
- ☐ Community Health Center (Sec. 330 or "Look-Alike")
- ☐ Community Mental Health Clinic (CMHC)
- ☐ Private For-Profit Clinic
- ☐ Public Clinic (operated by state or local government)
- ☐ Private Not-for-Profit Clinic
- ☐ Prison (Adult Corrections)
- ☐ Prison (Juvenile Justice Detention or Treatment)
- ☐ Tribal-Managed Health Facility
- ☐ Critical Access Hospital
- ☐ Hospital
- ☐ Hospital-Affiliated Clinic
- ☐ Local Health Department
- ☐ Long-Term Care Facility
- ☐ State Psychiatric Hospital
- ☐ Other

Briefly describe position

Position title #2	
Name of practice/agency	
Position dates	
Position total years	
Clinical or admin. supervisor	
Supervisor email	
Supervisor phone	
Occupation (discipline)	

Site type (*check ALL of the following that apply):*

- ☐ Certified Rural Health Clinic (CRHC)
- ☐ Community Health Center (Sec. 330 or "Look-Alike")
- ☐ Community Mental Health Clinic (CMHC)
- ☐ Private For-Profit Clinic
- ☐ Public Clinic (operated by state or local government)
- ☐ Private Not-for-Profit Clinic
- ☐ Prison (Adult Corrections)
- ☐ Prison (Juvenile Justice Detention or Treatment)
- ☐ Tribal-Managed Health Facility
- ☐ Critical Access Hospital
- ☐ Hospital
- ☐ Hospital-Affiliated Clinic
- ☐ Local Health Department
- ☐ Long-Term Care Facility
- ☐ State Psychiatric Hospital
- ☐ Other

Briefly describe position

Part C – Experience, *continued*	
Position title #3	
Name of practice/agency	
Position dates	
Position total years	
Clinical or admin. supervisor	
Supervisor email	
Supervisor phone	
Occupation (discipline)	

Site type (*check ALL of the following that apply):*

- ☐ Certified Rural Health Clinic (CRHC)
- ☐ Community Health Center (Sec. 330 or "Look-Alike")
- ☐ Community Mental Health Clinic (CMHC)
- ☐ Private For-Profit Clinic
- ☐ Public Clinic (operated by state or local government)
- ☐ Private Not-for-Profit Clinic
- ☐ Prison (Adult Corrections)
- ☐ Prison (Juvenile Justice Detention or Treatment)
- ☐ Tribal-Managed Health Facility
- ☐ Critical Access Hospital
- ☐ Hospital
- ☐ Hospital-Affiliated Clinic
- ☐ Local Health Department
- ☐ Long-Term Care Facility
- ☐ State Psychiatric Hospital
- ☐ Other

Briefly describe position

Position title #4	
Name of practice/agency	
Position dates	
Position total years	
Clinical or admin. supervisor	
Supervisor email	
Supervisor phone	
Occupation (discipline)	

Site type (*check ALL of the following that apply):*

- ☐ Certified Rural Health Clinic (CRHC)
- ☐ Community Health Center (Sec. 330 or "Look-Alike")
- ☐ Community Mental Health Clinic (CMHC)
- ☐ Private For-Profit Clinic
- ☐ Public Clinic (operated by state or local government)
- ☐ Private Not-for-Profit Clinic
- ☐ Prison (Adult Corrections)
- ☐ Prison (Juvenile Justice Detention or Treatment)
- ☐ Tribal-Managed Health Facility
- ☐ Critical Access Hospital
- ☐ Hospital
- ☐ Hospital-Affiliated Clinic
- ☐ Local Health Department
- ☐ Long-Term Care Facility
- ☐ State Psychiatric Hospital
- ☐ Other

Briefly describe position

Part D – Questions
Please describe those aspects of your personal, academic and/or employment history that you believe make you highly suited to provide healthcare to Alaska's underserved populations. *(limit 150 words)*
Please feel free to provide any other comments that you believe will help SHARP to determine your eligibility and priority for this support-for-service program. *(limit 150 words)*

Alaska's SHARP Program

Providing support-for-service to healthcare practitioners

Practitioner Application – Signature Page

I certify via my signature below that all information and data contained in the here-attached SHARP Carryover - Behavioral Health Specific Solicitation Practitioner Application, and in any other document(s) that I submit at any time, are accurate and can be substantiated by records review.

These documents and/or data include but are not limited to: work experience, education, practitioner background, occupational licensure, and any other concurrent service obligation(s).

I hereby certify, under penalty of revocation of my Alaska SHARP MOA service contract and other potential penalties, that to the best of my ability all submitted data are true.

For: HEALTH CARE PRACTITIONER (aka Clinician)

By: _____ _____

(Signature of Practitioner) Date

Practitioner's Name - print: _____

Notary Public: _____ _____

(Notary re: Practitioner's Signature) Date

(print, sign, and scan this page)