

Alaska's SHARP Program
Providing Support-for-Service to Healthcare Practitioners
SHARP II - Practitioner Application: Part A(1)

Applicant name:	Sponsoring agency (employer or potential employer):	Date:
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Instructions:
This form must be completed by the practitioner applying for SHARP, regarding either loan repayment or direct incentive. It must be typed, then printed, signed, and then emailed back as PDF attachment, attention SHARP program manager. Your SHARP single-submission application must include:

- Part-A: Practitioner application - completed by practitioner
- Part-B: Practitioner application - completed by practitioner and lenders/loan holder(s) - IF - loan repayment is being requested
- Part-C: Site application & declaration of intent - completed by sponsoring employer - IF - practitioner has identified an employer

Contract Information
If you have either a current, relevant employer, or a likely employer, then you must discuss your application with your employer before applying to SHARP. One reason for this is that your employer will be required to sign documents on your behalf, and to contribute matching funds. All SHARP-II contracts are for three years of service.

Personal Information

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

Last name	First name	Middle name	Social Security #	<input type="checkbox"/> Male	<input type="checkbox"/> Female
Date of birth:					
Address		City	State	Zip	
Are you an American Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Home phone		Cell Phone	Home e-mail		
What race are you? (check all races with which you identify)			Hispanic ethnicity: <input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> American Indian, Alaska Native, Eskimo or Aleut		<input type="checkbox"/> Native Hawaiian or Other Pacific Islander		*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 Multiracial.	
<input type="checkbox"/> Asian		<input type="checkbox"/> White			
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Some Other Race(s)			
Are you Multi-Racial?* <input type="checkbox"/> Yes <input type="checkbox"/> No					

Educational and Professional Information

Professional designation: Check & write one. This is total list of eligible occupations			State of licensure: <input type="checkbox"/> Alaska <input type="checkbox"/> Other _____		
<input type="checkbox"/> Physician	<input type="checkbox"/> Dentist	<input type="checkbox"/> Pharmacist	<input type="checkbox"/> Physical Therapist		
<input type="checkbox"/> Physician Assistant	<input type="checkbox"/> Dental Hygienist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Clinical Social Worker		
<input type="checkbox"/> Nurse Practitioner	<input type="checkbox"/> RN-Nurse	Write your licensed occupation: _____			
If MD or DO, what is your specialty?			License number: _____		
Name of Medical/Nursing/Dental/PA/Graduate School					
School address		City	State	Zip	
Beginning date of medical/graduate/dental education:			Graduation date:		
Residency program (if applicable):			Completion date:		
Address		City	State	Zip	
Will you be providing prenatal care? <input type="checkbox"/> Yes →	If yes, will you work at least 40 hours per week, spending at least 21 hours per week providing direct primary care in an ambulatory setting during normally scheduled office hours? <input type="checkbox"/> Yes <input type="checkbox"/> No				
	<input type="checkbox"/> No →	If no, will you work at least 40 hours per week, spending at least 32 hours per week providing direct primary medical, dental or behavioral care in an ambulatory setting during normally scheduled office hours. <input type="checkbox"/> Yes <input type="checkbox"/> No			

SHARP II - Practitioner Application: Part A(2)

Practitioner Questions - Continued

What level of SHARP support are you requesting (i.e. portion of FTE)?	Full-Time?	Half-Time?	Either Full or Half Time?
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Are you applying to SHARP for a position into which you are already hired?	YES	NO	
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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?	<input type="checkbox"/> 100%	<input type="checkbox"/> 75%	<input type="checkbox"/> 25% <input type="checkbox"/> 10%

Is this job a direct patient care position?	YES	NO	Don't Know
If Yes, what portion of your position involves direct patient care duties?	<input type="checkbox"/> 100%	<input type="checkbox"/> 75%	<input type="checkbox"/> 25% <input type="checkbox"/> 10%

Is this job a primary care position?	YES	NO	Don't Know
If Yes, what portion of your position involves delivery of primary care?	<input type="checkbox"/> 100%	<input type="checkbox"/> 75%	<input type="checkbox"/> 25% <input type="checkbox"/> 10%

Which type of support are you requesting?	Loan Repayment?	Direct Incentive?	Both?
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Loan Repayment is exempt from federal personal income taxation

Direct incentive eligibility is based on the practitioner's documented length & type of clinical experience

In addition, direct incentive benefit is treated as regular income, & thus is NOT exempt from federal personal income taxation

SHARP provides two different levels of support: (a) one for regular-fill positions and (b) one for very hard-to-fill positions

Which of the two position-types are you requesting SHARP support for?	Very-Hard-To-Fill?	Regular-Fill?
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Determination as to whether a position is (a) regular-fill, or (b) very hard-to-fill is a SHARP program function, done after data are collected from the employer (site). Data such as duration of vacancy, and length & type of recruitment strategy, assist us in making this determination. Further, the clinician-applicant should discuss this issue of position-type with his/her putative employer.

Do you NOW have another service obligation with any other entity?	YES	NO
Do you anticipate having a service obligation with any other entity during the SHARP contract-period?	YES	NO

If you have, or anticipate having, any other service obligation then you must declare this to the SHARP program now and at time of SHARP contract signing. SHARP is not available for practitioners who have other service obligation(s), though there are specific exceptions. If you have or will have another service obligation, discuss this with SHARP program staff to determine possible options.

If you answered "Yes" to either of these questions, which entity is the obligation with, or will be with?

If you answered "Yes" to either of these questions, check ANY other service obligation(s) that you have, or anticipate having:

- | | |
|--|---|
| <input type="checkbox"/> National Health Service Corp - Loan Repayment | <input type="checkbox"/> Indian Health Service Loan Repayment Program |
| <input type="checkbox"/> National Health Service Corp - Scholars Program | <input type="checkbox"/> Nurse Education Loan Repayment Program (aka NURSE Corps LRP) |
| <input type="checkbox"/> WWAMI Medical School tuition service obligation | <input type="checkbox"/> Active Military |
| <input type="checkbox"/> USPHS Commissioned Officers Corp | <input type="checkbox"/> National Guard |
| <input type="checkbox"/> Employer-provided sign-on bonus service obligation | <input type="checkbox"/> Reserve Military |
| <input type="checkbox"/> Employer-provided moving expense service-obligation | <input type="checkbox"/> Private foundation (specify): _____ |
| <input type="checkbox"/> Any other service obligation (specify): _____ | |

Sign & date this application below. Your signature below as the practitioner-applicant attests that all information here-submitted is true to the best of your understanding. Further, you acknowledge & accept that additional information may be requested for determining program eligibility and/or prioritization, and/or for program monitoring & reporting purposes. In the event that this practitioner application contains substantive factual errors, Alaska DHSS reserves the right to deem any SHARP Program agreement(s) with this practitioner as null and void.

Practitioner Signature & Date	Practitioner's Name (Printed)

SHARP II - Practitioner Application: Part A(3)

Practice Site Information

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 Services Shortage Area. The sponsoring agency is the health care system or organization that owns the practice site.

Practice Site 1

Practice Site Name:	Name of Sponsoring Agency		
Practice Site Address:	City:	State	Zip
Work Phone:	Work E-Mail:		
Date of Employment, or Expected Date:	Hours Worked Per Week, or Expected Hours		
Check ALL of the following that describe the Practice Site:			
<input type="checkbox"/> Certified Rural Health Clinic (CRHC)	<input type="checkbox"/> Drug Treatment Facility		
<input type="checkbox"/> Community Health Center (Sec 330 CHC) or "Look-Alike"	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Community Mental Health Clinic (CMHC)	<input type="checkbox"/> Hospital-Affiliated Clinic		
<input type="checkbox"/> Critical Access Hospital (CAH)	<input type="checkbox"/> Local Health Department		
<input type="checkbox"/> Private For-Profit Clinic	<input type="checkbox"/> Long-Term Care Facility		
<input type="checkbox"/> Public Clinic (operated by state or local government)	<input type="checkbox"/> Prison (Adult Corrections)		
<input type="checkbox"/> Private Not-for-Profit Clinic	<input type="checkbox"/> Prison (Juvenile Justice Detention or Treatment)		
<input type="checkbox"/> Tribal-Managed Health Facility	<input type="checkbox"/> State Psychiatric Hospital		

Other, Specify:

Practice Site 2 (if applicable)

Practice Site Name:	Name of Sponsoring Agency		
Practice Site Address:	City:	State	Zip
Work Phone:	Work E-Mail:		
Date of Employment, or Expected Date:	Hours Worked Per Week, or Expected Hours		
Check ALL of the following that describe the Practice Site:			
<input type="checkbox"/> Certified Rural Health Clinic (CRHC)	<input type="checkbox"/> Drug Treatment Facility		
<input type="checkbox"/> Community Health Center (Sec 330 CHC) or "Look-Alike"	<input type="checkbox"/> Hospital		
<input type="checkbox"/> Community Mental Health Clinic (CMHC)	<input type="checkbox"/> Hospital-Affiliated Clinic		
<input type="checkbox"/> Critical Access Hospital (CAH)	<input type="checkbox"/> Local Health Department		
<input type="checkbox"/> Private For-Profit Clinic	<input type="checkbox"/> Long-Term Care Facility		
<input type="checkbox"/> Public Clinic (operated by state or local government)	<input type="checkbox"/> Prison (Adult Corrections)		
<input type="checkbox"/> Private Not-for-Profit Clinic	<input type="checkbox"/> Prison (Juvenile Justice Detention or Treatment)		
<input type="checkbox"/> Tribal-Managed Health Facility	<input type="checkbox"/> State Psychiatric Hospital		

Other, Specify:

Add more pages for more anticipated Practice Sites - if necessary

Alaska's SHARP Program
Providing Support-for-Service to Healthcare Practitioners
SHARP II - Practitioner Application: Part B(1) - Lender

Loan - Lender/Holder Information Form - Required for Loan Repayment Support
INSTRUCTIONS

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 a consolidator 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.

To the Applicant (Borrower)

Completion of this Part B of the practitioner application takes considerable time to complete, fill in & print or email.

- 1 Complete one copy of the practitioner application for each lending organization that holds on or more of your loans - by **typing Section I** and printing the form.
- 2 Mail or fax a copy to each organization that holds your loans. You must include a copy of these instructions, and ask them to complete Section II and then emailed as attachment it back to **you**. *Organizations may list up to 4 loans in the table provided. If a single holder holds more than 4 loans, you must send additional copies so that all loans can be listed in the table provided. For example, if one holder had 11 loans, you would need to send 3 copies.*
- 3 You must receive the completed Parts B back in time to include them with your complete, single-submission SHARP-II application package, which you must emailed as attachment to the AK SHARP office with the required postmark date for that application period.

By your signature in Section I, you authorize the lender and/or holder of the promissory note/service obligation(s) for your student loan/service obligation(s) to release information about your student loan/obligation(s) to Alaska Department of Health & Social Services for purposes of qualifying the loan(s) for repayment by the State of Alaska under provisions of the SHARP program.

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 above). You may list up to 4 in the table included in Section II. If necessary, fill out additional copies of the Part B application.

SHARP-II Option-II – Practitioner Application Part-C: Direct Incentive Request Form

SHARP-II provides the opportunity for direct incentive to selected participating healthcare practitioners. If direct incentive support is requested, this form must be completed.

In designating a clinician as eligible for direct incentive, SHARP will give priority to experienced healthcare professionals over those with less experience. The Program will consider both the type and the length of the healthcare professional's relevant work experience as a licensed health care professional in that occupation for which the practitioner seeks SHARP support-for-service benefit(s). Whether any clinician-applicant will be authorized for direct incentive is at the discretion of, and based on the prioritization by Alaska DHSS.

Item-1: Check & initial which SHARP-eligible occupation you are licensed in, and regarding the Alaska-licensed practice for which you are seeking the direct incentive benefit.

Tier-1: Physician	Tier-1: Dentist
Tier-1: Pharmacist	Tier-2: Dental Hygienist
Tier-2: Physician Assistant	Tier-2: Nurse Practitioner
Tier-2: Psychologist	Tier-2: Nurse-RN
Tier-2: Social Worker	Tier-2: Physical Therapist

Item-2: Indicate the State, license # and date upon which you first practiced with a full, permanent and unencumbered license.

State	License #	Date of Full License

Item-3: List your (a) school, post-graduate or professional program, and (b) residency program (if applicable), and graduation or completion date of the degree required for your employment.

School, Program, Residency	State	Graduation Date

Item-4: Present chronology of directly relevant, fully licensed clinical work experience (If needed, copy this page to add more). Program priority is based, in part, on the length, extent & type of directly relevant licensed clinician experience. Your application will be compared with others to determine priority for receipt of direct incentive.

Position Title:

Type of Practice Site	Name of Practice /Agency	Dates & Total Years
Clinical or Admin. Supervisor	Email	
Brief Practice Description		
State how this Position/Background is relevant to you being categorized as "Highly Experienced"		

Position Title:

Type of Practice Site	Name of Practice Location	Dates & Total Years
Clinical or Admin. Supervisor	Email	Phone
Brief Practice Description		
State how this Position/Background is relevant to you being categorized as "Highly Experienced"		

Use additional pages as necessary

Item-5: State the total number of years that you have worked as a licensed healthcare practitioner in that occupation for which you now seek the direct incentive.

	Total # of Years	Year Practice Began	Initial & Date Here
Number of years you have worked as a licensed practitioner in THIS occupation			

Item-6: Signature here by the Clinician-Applicant is assertion that all information here-provided by the Clinician is true & correct to the best of his/her knowledge and belief. This signature also indicates that the Clinician-Applicant knows that the direct incentive is treated as regular income for purposes of federal personal income taxation, and is NOT exempt.

_____ Clinician's Signature - & Date	_____ Printed Name of Clinician
_____ Phone number	_____ Email address

Experienced: Program manager's initial signature below indicates that this clinician-applicant is identified as priority candidate as regards the practitioner's occupation-type. Whether the clinician-applicant is accepted into SHARP-II, and is actually provided direct incentive benefit, depends on additional factors as well.

_____ SHARP Program Manager	_____ Date
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Approval of Direct Incentive: Program manager's final signature below is provided after the current pool of applicants and set of currently available positions is reviewed. Signature below indicates that the applicant is authorized to receive direct incentive.

_____ SHARP Program Manager	_____ Date
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