



Licensed Mental Health Service Provider Education Program

Loan Repayment Application

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 a publicly funded or public mental health facility or a non-profit private mental health facility in underserved communities

Application Instructions



If you want receipt confirmation of your application packet, please submit one self-addressed stamped envelope with 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 licensed 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 their mental health service provider education.

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.

“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.

Qualified facilities are defined as one of the following:

(1) “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.

(2) “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 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.

(3) “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 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 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 licensed 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 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 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.

LOAN REPAYMENT ELIGIBILITY

Loan repayment awards are available to licensed mental health service providers who hold a full and unrestricted license to practice in California or are registered Marriage and Family Therapist or Clinical Social Worker in good standing. “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, marriage and family therapist, marriage and family therapist intern, licensed clinical social worker, and associate clinical social worker.

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 thirty-two (32) hours. Direct patient care” means the provision of health care 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.”

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

Application Instructions (cont.)



PROGRAM ELIGIBILITY CRITERIA

The most qualified applicants will be selected in the areas of California with the greatest workforce need: qualified facilities or an MHPSA. Priority consideration will be given to the applicants best suited to meet the cultural and linguistic needs and demands of patients, 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 linguistically competence.

*Service obligation must be fulfilled by providing direct patient care on a full-time basis (minimum of 32 hrs. per week) upon signing of contract.

Career Goals - professional goals for the next five to ten years.

Community Service - documented volunteer service and/or activities, particularly in a MHPSA or qualified facility.

Community Background - family structure and community where applicant grew up.

Cultural and Linguistic Competency - fluency in a language other than English must be verified on the Employment or Volunteer Verification Form or in a letter of recommendation from employer. Qualifying language includes: Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese.

Priority will be given to those applicants whose community background and commitment indicates the likelihood of long-term employment in a mental health professional shortage area 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. Only complete applications will be evaluated. The Foundation will 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

Your statement must be typed and no more than two (2) pages total. Statement must provide a comprehensive response to each question. Restate and number each question along with your answer.

3. Employment or Volunteer Verification Form

This form must be signed by an official in your personnel or human resources department. The Employment or Volunteer Verification Form is enclosed as part of the application. Applicants can also download this form from the Foundation's Web site at www.healthprofessions.ca.gov.

4. Educational Debt Reporting Form

Submit the attached educational debt reporting form and copies of your most recent lender statements (no more than six (6) months old) with your name, the name of lender, balance owing, account number, and monthly payments. All information must be filled in or the application will be considered incomplete.

5. Two Professional Letters of Recommendation

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

6. Proof of Registration or Licensure

A copy of a document which includes a license number issued by the California Board of Behavioral Sciences or the California Board of Psychology, or proof of registration, including registration number issued by the California Board of Behavioral Sciences, or a unique identification number issued by the California Board of Psychology.

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. 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.

SPRING POSTMARK DEADLINE: MARCH 24, 2008
FALL POSTMARK DEADLINE: SEPTEMBER 11, 2008

Submit applications to:

Health Professions Education Foundation
Licensed Mental Health Service Provider Education Program
400 R Street, Suite 330
Sacramento, CA 95811
(800) 773-1669 or (916) 326-3640

Application

Last Name

First Name



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.

Do you owe an existing service obligation to another entity? Yes No 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.)

<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms. <input type="checkbox"/> Dr.		Last Name:		First Name:		Middle Initial:	
CA Drivers License Number:				*Social Security Number:			
Mailing Address:							
City:			State:		Zip:		
County:							
Permanent Address (if different than above):							
City:			State:		Zip:		
County:							
Home Phone: ()				Date of Birth:			
Cell Phone: ()				E-mail Address:			
Work Phone: ()				Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Are you a citizen or permanent resident of the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No				Are you a California resident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Which CA Board are you registered or licensed with? <input type="checkbox"/> Behavioral Science <input type="checkbox"/> Psychology				License or Registration #:			
Which field did you or are you completing studies in? <input type="checkbox"/> Marriage & Family Therapy <input type="checkbox"/> Clinical Social Work <input type="checkbox"/> Psychology							
Which best describes your ethnic background (optional):							
<input type="checkbox"/> African American		<input type="checkbox"/> Caucasian		<input type="checkbox"/> Native American			
<input type="checkbox"/> Asian American		<input type="checkbox"/> Hispanic/Latino		<input type="checkbox"/> Pacific Islander			
<input type="checkbox"/> 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.

FOR OFFICIAL USE ONLY

Recd:	Compl / Inc:	Omitted: App Pgs	EVF	EDR	Per State	LoR	PL/R
Input By:	Elig Prac Set: Yes / No	CT#:					
Reviewed By:	Comments:						

Applicant's Name: _____

PART B – WORK EXPERIENCE

1. How many years have you worked in a qualified facility or an MHPSA? _____
2. Do you currently provide direct patient care in or through a qualified facility or MHPSA?
 Yes No
3. How many contact hours have you had in cultural and linguistically appropriate service delivery? _____

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) in California?
 Yes No

PART D – LINGUISTIC COMPETENCY

1. Check any Medi-Cal threshold languages that you are fluent in. Please submit verification (see Cultural and Linguistic Competency in the instructions).

- | | | |
|------------------------------------|--|-------------------------------------|
| <input type="checkbox"/> Arabic | <input type="checkbox"/> Hmong | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Armenian | <input type="checkbox"/> Korean | <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Cambodian | <input type="checkbox"/> Mandarin | <input type="checkbox"/> Tagalog |
| <input type="checkbox"/> Cantonese | <input type="checkbox"/> Other Chinese | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Farsi | | |

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. How would your socioeconomic background benefit you in service under this program and would it benefit the patient population?
4. Describe any community service, volunteer activities, and club/organizational memberships which you have for the past two (2) years been involved with. Please include the length of time you have been committed to these groups.
5. What is your professional vision for the next five (5) to ten (10) years, as it relates to a mental health profession?
6. Please add any other information you believe is relevant.

PART F – QUESTIONNAIRE

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

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

- | | |
|---|--|
| <input type="checkbox"/> Work (employer or co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> TV | <input type="checkbox"/> Radio |
| <input type="checkbox"/> Other Web site | <input type="checkbox"/> Foundation Web site |
| <input type="checkbox"/> Newspaper or publication (please specify) _____ | <input type="checkbox"/> Advertisement |
| <input type="checkbox"/> Organization or Affiliation (please specify) _____ | |
| <input type="checkbox"/> Other source (please specify) _____ | |

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

- | | |
|---|--|
| <input type="checkbox"/> Program Director/Instructor | <input type="checkbox"/> Foundation office |
| <input type="checkbox"/> Foundation Web site | <input type="checkbox"/> Other Web site |
| <input type="checkbox"/> Work (employer/co-worker) | <input type="checkbox"/> Friend/Acquaintance |
| <input type="checkbox"/> 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 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.

Name (please print)

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 and Lender Statements
- 4. Personal Statement
- 5. Two (2) Professional Letters of Recommendation
- 6. Proof of licensure or registration

Employment or Volunteer Verification Form



**ATTENTION! The completed form must bear an original ink signature.
Photocopies and faxed copies of the completed form are not acceptable.**

FORM TO BE COMPLETED BY AN OFFICIAL IN THE PERSONNEL OR HUMAN RESOURCES DEPARTMENT
(The person signing this form may not be related to the applicant by blood, marriage, or adoption)

Employee's or Volunteer'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: _____ Advocacy: _____ 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: _____

Through our selection process, I have determined that the applicant can speak the following Medi-Cal threshold language(s):

Arabic

Armenian

Cambodian

Cantonese

Farsi

Hmong

Korean

Mandarin

Other Chinese

Russian

Spanish

Tagalog

Vietnamese

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 administrative officer at this facility, which meets the definition of a "qualified facility.*" This information will be verified with the Health Professions Education Foundation.

I declare under penalty of perjury that these statements are true and correct.

Name: (Please Print) _____

Signature: _____

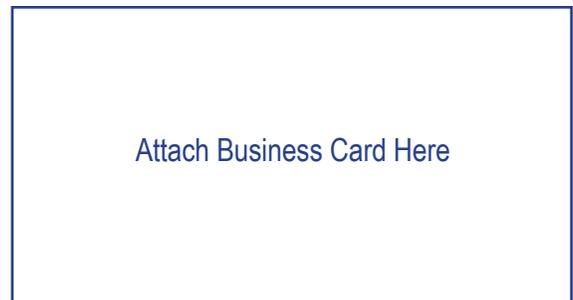
Title: _____

Phone Number: _____

Fax Number: _____

Email: _____

Date: _____



*Qualified facilities are defined as one of the following: (1) "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. (2) "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 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. (3) "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 Services that is operated by a non-profit entity that contracts with a county mental health entity or facility to provide mental health services.

Educational Debt Reporting Form



- List source and amounts of outstanding educational loans used to finance your education below.
- You must submit current lender statements (dated within 6 months) of the educational debts listed below. They should include the current balance, account number, your name, and address to which payment is submitted. **In the case of loan consolidation, please include proof of the original loan sources.**

All spaces must be completed. If payments are deferred an amount must be entered into the monthly payment space.
If any information is missing the application will be considered incomplete.

LOAN 1

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

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

Lender's Address: _____

City: _____ State: _____ Zip: _____

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: _____

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: _____

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: _____

Outstanding Balance: \$ _____ Monthly Payment: \$ _____



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