

VIRGINIA DEPARTMENT OF HEALTH- OFFICE OF HEALTH EQUITY- DENTAL SCHOLARSHIP AND LOAN REPAYMENT PROGRAM APPLICATION 2022

APPLICATION CHECKLIST AND REQUIREMENTS

The Commonwealth of Virginia has established the Dental Scholarship and Dental Loan repayment programs (DSLRLP). These programs are intended to help provide additional dental services in underserved areas of Virginia. Scholarships are awarded to students enrolled in an accredited school of dentistry or loan repayment to graduates of accredited dental schools. The Office of Health Equity (OHE) of the State Health Department serves as administers these programs.

This checklist is provided to facilitate the application process. Please ensure that all of the requirement documentations listed in the checklist are submitted as part of a complete application. **Incomplete applications will not be processed.** All applications are completed and submitted online at <https://www.vdh.virginia.gov/health-equity/incentive-programs>. **Application cycle: May 1 through June 30th**

Please check the box as you complete the following sections of the application.

- Section 1: Personal Data
- Section 2: Professional Education
- Section 3: Professional Experience Narrative
- Recommendation Letters (Two required)
- Section 4: School or Practice Site information
- Section 5: Educational Loan Debt Information
- Section 6: Certification of Application
- Section 7: Authorization of Release Form for all debt/ loans to be repaid through the VA-DSLRLP
- Section 8: Debt/Loan Certification
- Section 9: Certification of Non-Delinquent Status

Required documents to be considered for scholarship:

- Proof United States citizenship, United States national, or a qualified alien – Social security Card
- Proof of Virginia residency (at least 1 year) and resident of a dental underserved area in Virginia
- Proof of economically disadvantaged backgrounds
- Proof of cumulative GPA of at least 3.0- Office transcript required
- Proof of enrollment form must be completed by school of dentistry (template provided)
 - Students must not have entered the first year of an accredited residency
- Proof of financial need verified by school's financial aid office (template provided)
- Criminal History Check (send money and forms directly to the Virginia State Police and type YOUR name and address in the "Mail reply to" section of the application) or Background check completed with one year from your employer only.
- Copy of all educational invoices to show proof of anticipated or current debt

Required documents to be considered for Loan Repayment

- Proof United States citizenship, United States national, or a qualified alien – Social security Card
- Proof of Virginia residency (at least 1 year)
- The practice site has to be in a designated Dental Health Professional Shortage Area (dHPSA)
- Criminal History Check (send money and forms directly to the Virginia State Police and type YOUR name and address in the "Mail reply to" section of the application) or Background check completed with one year from your employer only.
- A signed Employment Contract (Candidates must be employed or have a contract to begin employment with an eligible practice site prior to submitting an application and include the salary, start date, discipline, obligation with employer and name of practice site).
- A copy of your current Virginia Dental License
- Proof of National Practitioner Identifier (NPI)
- Proof of graduation from an accredited dental school in the United States
- Copy of all qualifying dental educational debt loan applications and/or Loan Pay-off Statements

SECTION 1- PERSONAL DATA (SCHOLARSHIP/LOAN REPAYMENT)

Please complete the following by filling in the blank, checking the appropriate box, or using the drop down box:

Application Type: Please Select One

Date of Application: _____

Personal Demographics

- Applicant Full Name: _____
- Maiden Name or Alias (if appropriate): _____
- Street Address: _____
- City: _____ State: _____ Zip Code: _____
- Home Phone: (000) 000-0000 Work Phone: (000) 000-0000 Cell Phone: (000) 000-0000
- Other Phone: (000) 000-0000 E-Mail Address/es: _____
- Preferred Method of Contact: Home Phone Work Phone Cell Phone E-Mail
- Full Social Security Number: _____
- Date of Birth: _____ Birth Place (City, State, Country): _____
- Are you a U.S. Citizen or Naturalized Citizen? Please Select One
(Applicant must be a U.S. citizen or naturalized citizen to be eligible for program).
- Race/Ethnicity: Please Select One Other (specify): _____ Gender: Please Select One

Do you speak a Language(s) other than English? Please Select One

If so, please list and check whether you can read, write, and/or speak fluently:

Language: _____ Read Write Speak Fluently

Current and Professional Status:

In Practice/Employed Military Residency Other, (please describe):

History: Please check all that apply: History of noncompliance or other waivers of service or payment obligations to other loans Active military obligations History of delinquent child support Federal debt or lien against property for a debt to the United States

Background:

Are you from a disadvantaged background? Yes No

Please check all that apply and include details in your professional narrative:

- Social Disadvantaged Gender Cultural Disadvantaged
 Educational Ethnic Group Live in a Dental Underserved Area

SECTION 2 - PROFESSIONAL EDUCATION (SCHOLARSHIP/LOAN REPAYMENT)

Please complete the following by filling in the blank, checking the appropriate box, or using the drop down box:

Education:

Professional School Name: _____

City: _____ State _____ Zip Code: _____

Date began school: _____ Date of Graduation/Anticipated Graduation: _____

Post-graduate Training/Residency (if required): _____

Date Residency Began: _____ Date Completed: _____

Profession:

Please check your eligible discipline

- General Practice Dentist (D.D.S. or D.M.D.) Specialty Dentistry (specify): _____

License, Board Eligibility and Certification (Loan Repayment applicants):

Board Eligible: <u>Please Select One</u>	License Number: _____
National Practitioner Identifier (NPI): _____	State: _____
Board Certified <u>Please Select One</u>	Certificate Number: _____
Name of Board: _____	Date of Certification: _____
Any license restrictions? <u>Please Select One</u>	If yes, please specify: _____

SECTION 3 - PROFESSIONAL EXPERIENCE (SCHOLARSHIP/LOAN REPAYMENT)

Please provide a brief narrative/summary in one page or less addressing the following:

1. Comment on your experiences in rural or underserved urban areas.
2. Discuss your commitment to serve in this community/practice site.
3. What makes you an appropriate match for this community/practice site?
4. If you checked yes for disadvantaged background, please share your story.

Note: Please type your response in a separate document, include your name at the top of the page, and attach to your application.

SECTION 4 – PRACTICE SITE/SCHOOL (LOAN REPAYMENT)

**Please complete the following by filling in the blank or checking the appropriate box:
Facility must be on current, approved Dental HPSA listing to be eligible to apply. Applicant agrees to provide full-time, direct Dental care services at:**

Practice Site
Name/School:

Employer/Parent Organization (if
applicable):

Address:

City: _____ State: _____ Zip Code: _____

Practice Site Contact Person:

Title: _____ Phone Number: _____

E-Mail: _____ Congressional District: _____

I _____, applicant agrees to provide dental care services for:

2 years 3 years 4 years other _____

SECTION 5 - EDUCATIONAL DEBT/INVOICE (SCHOLARSHIP/LOAN REPAYMENT)

Please complete the following by filling in the blank. Be sure to attach a current invoice or loan statement with pay-off balance for each loan listed. Invoices and loan statements must be dated either the same or the prior month the application is submitted. The loan statements must contain the applicant's name, account number and principle and/or pay-off balance. Invoices must contain the applicant's name, account number and billed amount. VA-DSLRLP funds are to be used only to repay qualified educational loans.

Total Loans (Loan repayment)/Amount billed (Scholarship): _____

1. Loan Holder:

Loan Holder Address: _____
_____ State _____
City: _____ : _____ Zip Code: _____
Account Number: _____ Loan Balance: _____

2. Loan Holder:

Loan Holder Address: _____
_____ State _____
City: _____ : _____ Zip Code: _____
Account Number: _____ Loan Balance: _____

SECTION 6 - CERTIFICATION

Please fill in the blank or print and provide original signatures.

Certification: I hereby certify that the information given in this application is accurate and complete to the best of my knowledge and belief. I understand that it may be investigated and that any willful false representation is sufficient cause for rejection of this application.

Full Name (Print):	_____	Date:	_____
Full Signature:	_____		_____

SECTION 7 - AUTHORIZATION OF RELEASE FORM

Please fill in the blank, print, and provide original signatures.

I, _____, have applied to participate in the Virginia Dental Scholarship and Loan Repayment Program (VA-DSLRLP). This program offers Dental Care Providers an opportunity to practice their profession in a community that lacks adequate dental health care services while paying off outstanding educational loans or scholarship while in school. The amount awarded is to be used only to reduce the balance of principal and accrued interest in outstanding educational loans. As part of the application process, the Virginia Department of Health, Office of Health Equity may request, verify and share information contained in the scholarship and loan repayment application and in other documents required in connection with this program.

I authorize you to provide the Virginia Department of Health, Office of Health Equity any and all information and documentation that they request. A copy of this authorization may be accepted as an original.

Your prompt reply to the Virginia Department of Health is appreciated, as delays may impact my ability to promptly receive loan repayment funds.

Scholarship /Loan Repayment Applicant Name (Print)	Date
Scholarship/ Loan Repayment Applicant Signature	

Social Security Number

SECTION 8 – INVOICE/LOAN CERTIFICATION

Please fill in the blank, print, and provide original signatures.

I, _____, hereby certify to the accuracy of the invoice/loan information provided. I hereby apply to enter into an agreement with the Virginia Department of Health for repayment of outstanding educational loans or scholarship. I understand that funds received under this program shall be used exclusively for the repayment of outstanding educational loans, incurred solely for the costs of dental education, including reasonable living expenses. I further understand that I am responsible for, and must adhere to, all applicable federal income tax regulations.

I understand that the information I have provided is subject to verification, and any willfully false representation is sufficient cause for rejection of this application.

Loan Repayment Applicant Name (Print)

Date

Loan Repayment Applicant Signature

Social Security Number

SECTION 9 – CERTIFICATION OF NON-DELINQUENT STATUS

Please check the appropriate box, fill in the blank, print, and provide original signatures.

The Federal Debt Collection Procedures Act of 1990 precludes a debtor who has a judgment lien against his/her property arising from a federal debt from receiving federal funds until the judgment lien is paid in full or otherwise satisfied. Applicants for the Virginia Dental Scholarship and Loan Repayment Program

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(VA-DSLRLP) must certify that he/she does not have a judgment lien against his/her property arising from state or federal debt.

I hereby certify that I [do] [do not

I hereby certify that I [am] [am not

Scholarship/Loan Repayment Applicant Name (Print)

Date

Scholarship/ Loan Repayment Applicant Signature

Social Security Number

THANK YOU FOR YOUR INTEREST IN THE VA-DSLRLP.