

ILLINOIS DEPARTMENT OF PUBLIC HEALTH
CENTER FOR RURAL HEALTH

**DENTAL LOAN REPAYMENT ASSISTANCE
PROGRAM**

APPLICATION INFORMATION

WHAT IS THE PROGRAM'S PURPOSE?

The purpose of the Dental Loan Repayment Assistance Program is to increase the total number of dentists and dental specialists practicing in designated dental shortage areas in this State by providing educational loan repayment assistance. The program is authorized by the Loan Repayment Assistance for Dentists Act [110 ILCS 948].

WHO IS ELIGIBLE TO PARTICIPATE?

Program applicants must meet the following requirements:

- Applicant must be a citizen or permanent resident of the United States.
- Applicant must be a resident of Illinois.
- Applicant must be practicing full time in this State as a dentist or dental specialist. A dentist or dental specialist is a person who has received a general license pursuant to paragraph (a) of Section 11 of the Illinois Dental Practice Act [225 ILCS 25/11(a)], who may perform any intraoral and extraoral procedure required in the practice of dentistry, and to whom are reserved the responsibilities specified in Section 17 of the Illinois Dental Practice Act.
- Applicant must currently be repaying educational loans.
- Applicant must continue full-time practice in this State in a designated shortage area for two years.
- The grant payments must be used for the repayment of educational loans, including principal, interest and related expenses of government and commercial loans, received by the grantee and used for tuition expenses while attending a registered professional dental education program in this State.

WHAT ARE THE SELECTION CRITERIA?

- At least one of the awards will be given to a dentist and a dental specialist when qualified applicants are available.
- Applicant selection will be based on the following criteria:
 - 1) All eligible applications will be divided into two groups:
 - A) Dentists
 - B) Dental Specialists
 - 2) These two groups will be ranked by Dental HPSA score from highest to lowest with highest need awarded first.
 - 3) Fifty percent of awards will be made to urban practitioners and fifty percent to rural practitioners.

WHAT IS THE AMOUNT OF FINANCIAL ASSISTANCE?

- For each year that a selected grant recipient practices full time in this State in a designated shortage area as a dentist or dental specialist, the Department shall, subject to appropriation, award a grant in an amount equal to the amount in educational loans that the person must repay that year. The total amount in grants that a person may be awarded in this program shall not exceed \$25,000 per year for a four year period.
- Payments must be used for the repayment of higher education loans that a grant recipient has incurred in attending a registered professional dental education program in this State.
- Applicants may apply for an initial two-year grant and one additional two year grant. Grant recipients may submit a new application for education loan repayment assistance to receive the additional two year grant as long as they continue to meet the eligibility requirements.

WHAT ARE THE PROGRAM REQUIREMENTS?

- The grantee is required to engage in a full-time dental or dental specialist practice located in a Dental Health Professional Shortage Area (HPSA).
- The grantee is required to engage in a full-time dental practice with a 40-hour work week where at least 32 hours of the 40 hours per week are spent providing clinical services. These services must be conducted during normally scheduled clinic hours in the ambulatory care setting office(s) specified in the grant agreement. The remaining hours shall be spent providing inpatient care to patients of the clinic and/or in practice-related administrative activities.
- The 40 hours per week may be compressed into no less than four days per week, with no more than 12 hours of work to be performed in any 24 hour period. Time spent in “on call status” will not count toward the 40 hour week. Hours worked over the required 40 hours per week will not be applied to any other work week.

- No more than seven weeks (35 work days) per year can be spent away from the practice for vacation, holidays, continuing professional education, illness or any other reason. Absences greater than seven weeks in a service year will extend the service commitment end date.
- Applicants must accept dental payments for services rendered under Article V of the Illinois Public Aid Code [305 ILCS 5/Art,V], administered by the Department of Healthcare and Family Services (HFS).
- Each dentist or dental specialist selected for educational loan repayment shall enter into a written grant agreement with the Department that describes terms of the repayment and contains provisions for enforcement of the agreement.
- All loan repayment paid to the grantee must be used to repay the approved qualifying educational loans.
- Mandatory reporting requirements every six months include:
 1. The grantee will provide documentation of the percentage of low income patients served in his or her practice. Medical assistance reimbursement documentation and practice documentation will be accepted for this purpose.
 2. The grantee shall provide documentation that the amount of money paid for educational loan debt is greater than or equal to the amount of money paid by the Department under this program. Documentation from the lending institution will be accepted for this purpose.

HOW WILL PAYMENTS BE MADE?

The Department will issue payments on a quarterly basis following the completion of each three-month period of compliance with the terms of the grant agreement. Grant recipients will be responsible for payments to the financial institutions holding their educational loans.

WHAT ARE THE PENALTIES FOR FAILURE TO FULFILL THE OBLIGATION?

- Grant recipients who fail to practice full time in a designated dental shortage area, as provided in the rules, shall repay the Department a sum equal to the amount received under the program, plus an annual percentage rate (APR) of 7% interest.
- Repayment shall be made in such amounts so that all sums due shall be paid within a period of time equal to the recipient's service term.
- Grant recipients who wish to move their practice from the location described in the recipient's original application must receive approval from the Department and must relocate to an area which qualifies for the same or a higher priority ranking. Relocating to a lower priority area will result in a breach of the loan repayment grant agreement.

- False information presented in the application or not fulfilling the grant requirements will be considered a breach of the grant agreement. Any funds provided by the Department for the repayment of educational loans shall be repaid within a period of time equal to the grantee's service term.
- In the event the grant recipient does not repay any funds owed to the Department within a period of time equal to the grantees' service term, the Department shall refer the matter to the Attorney General or to a collection agency.

HOW IS APPLICATION MADE?

- Applications shall be accepted initially for funding between May 15 and June 1 and awarded by June 25, 2009, subject to appropriation. Applications must be postmarked by June 1, 2009. If enough eligible applications are received, all awards will be made. However, if funds remain available, subsequent applications will be evaluated individually as received.
- Applications are available from IDPH's Center for Rural Health. Completed applications should be sent to:

Center for Rural Health
Illinois Department of Public Health
535 W Jefferson St
Springfield, IL 62761
Attn: Dental Loan Repayment Program
- For further information, please contact the Center for Rural Health at 217-782-1624 or TTY (hearing impaired use only) 800-547-0466.

**ILLINOIS DEPARTMENT OF PUBLIC HEALTH
CENTER FOR RURAL HEALTH
DENTAL LOAN REPAYMENT ASSISTANCE**

A P P L I C A T I O N

Name

(First) (Middle Initial) (Last)

Home Address

(Street)

(City/State/ZIP)

(Telephone)

Office Address

(Street)

(City/State/ZIP)

(Telephone)

E-mail Address

Date of Birth

Race/Ethnicity*
(optional)

___ American Indian or Alaska Native

___ Asian

___ Black or African American

___ Hispanic

___ Native Hawaiian or Other Pacific Islander

___ White, not Hispanic

What is your profession/specialty?

Dentist

Dental Specialist - *endodontics*

Dental Specialist - *oral and maxillofacial surgery*

Dental Specialist - *orthodontics*

Dental Specialist - *pedodontics*

Dental Specialist - *periodontics*

Dental Specialist - *prosthodontics*

Dental Specialist - Other

Are you a United States citizen ____ Yes ____ No

If No, are you a permanent resident? ____ Yes ____ No

Are you an Illinois resident? ____ Yes ____ No

If yes, how many years have you lived in Illinois? _____

Are you currently licensed in Illinois? ____ Yes ____ No

(If yes, please attach a copy of your license.)

Are you practicing full-time in Illinois as a dentist or dental specialist?

____ Yes ____ No

Are you currently repaying educational loans, from government or other commercial sources received by you for tuition expenses while attending a registered professional education program? ____ Yes ____ No

EDUCATION

Dental School Attended (Provide Name, City, State and Year of Graduation.)

PRACTICE LOCATION

Where do you intend to practice (or are now practicing) to qualify for this program?

(Group/Center/Clinic Name)

(Street Address – No P.O. Box)

(City/ZIP)

(Telephone)

When did you or will you begin practicing in this location? _____

(Month/Year)

Is this location a federally-designated dental health professional shortage area?

HPSA ____ Yes ____ No

HPSA ID _____

For Office Use Only

List the outstanding balances of your dental school loans, by lender. *Copies of loan balance statements must be attached to the application.

Lender's Name	Balance
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

*DOCUMENTATION SHOULD SPECIFY THE LENDING INSTITUTION OR AGENCY, LOAN AMOUNT, LOAN PERIOD, INTEREST RATE AND REQUIRED MONTHLY PAYMENTS.

APPLICANT CERTIFICATION

Release/ Certification Statement

I hereby agree that the Department of Public Health may verify any and all statements in this application. I grant permission to applicable lending institutions to release all information requested by the Illinois Department of Public Health relevant to my dental school loans. I certify that I am not presently in default on payments for any previously received state or federal educational funds. I also hereby certify that the information submitted in this application is a true record.

Applicant's Signature

Date

Social Security Statement

The Illinois Department of Public Health requests your social security number. You are not required to disclose your social security number at this time, and no rights, benefits, or privileges will be denied if you choose not to disclose your number. Be advised, however, your number may be required at a later date. If you choose to disclose your social security number now, please sign this form and add your number as shown.

SOCIAL SECURITY NUMBER: ___ ___ - ___ - _____

Applicant's Signature

Date