DEPARTMENT OF HEALTH AND HOSPITALS
Bureau of Primary Care and Rural Health

LOUISIANA STATE LOAN REPAYMENT PROGRAM FOR PRIMARY CARE HEALTH CARE PROFESSIONALS

REVISED MARCH 30, 2016

For More Information Contact:

Beth Butler
HPSA Coordinator/SLRP Program Monitor
Bureau of Primary Care and Rural Health
Louisiana Department of Health and Hospitals - Office of Public Health
628 North 4th Street or P.O. Box 3118
Baton Rouge, LA 70821.3118
225.342.4702 Office
225.342.5839 Fax
beth.butler@la.gov Email

TABLE OF CONTENTS

Louisiana State Loan Repayment Program for Health Care Professionals

Statutory Authority

Section 338I of the United States Public Health Service (PHS) Act, 42 U.S.C. 254q-1, authorizes the Secretary of Health and Human Services, through the Health Resources and Services Administration, to make grants to States, which are funded through federal grant funds, which are matched $1 for $1 by the states with non-federal funds. These grants are to assist the states in the repayment of educational loans of health professionals who agree to provide primary health services in federally designated Health Professional Shortage Areas (HPSAs). The term HPSA, as used in this document, means a federally designated HPSA under Section 332 of the PHS Act, as amended.

Background, Purpose and Mission

The federal State Loan Repayment Program (SLRP) grants were established in 1987. All 50 states are eligible to apply for the SLRP funds. The grant awards to states range from $50,000 to $1,000,000, and the average grant award is $250,000.

The purpose of the Louisiana SLRP is to encourage health professionals to serve in a HPSA. The mission of the program is to alleviate and ultimately overcome the state's problem of a substantial deficit of primary care health professionals in underserved rural and urban areas.

Administration of Program

The Louisiana Department of Health and Hospitals' (DHH) Bureau of Primary Care and Rural Health (Bureau) is responsible for administering the Louisiana SLRP. The Bureau will contract only with professionals who are licensed by the Louisiana State Board of Medical Examiners, the Louisiana State Board of Nurse Examiners, the Louisiana Board of Dentistry, the Louisiana State Board of Examiners of Psychologists, the Louisiana Licensed Professional Counselors Board of Examiners or the Louisiana State Board of Social Work Examiners.

Health Professional Shortage Areas

Since 1976, the PHS has been charged with designating HPSAs throughout the United States. including:

- Population groups (i.e. Medicaid population, low income population, etc.).
- Public, non-profit and private medical facilities throughout the United States that have a shortage of various types of health professionals.
- Parishes, census tract groupings and facilities are also designated as HPSAs at the request of the DHH Bureau of Primary Care and Rural Health, according to the definitions and procedures of Section 332 of the PHS Act, as amended [Title 42, U.S. Code, Section 254e] and Title 42 of the Code of Federal Regulations, Part 5.

Louisiana has approximately 235 primary care, 158 dental, and 168 mental HPSA designations, which include rural parishes, as well as urban areas and facility designations. SLRP placement sites must be located in discipline-specific designated HPSA. To find your HPSA go to: http://datawarehouse.hrsa.gov/tools/analyzers/geo/ShortageArea.aspx .
NOTE: Refer to Appendix E for maps of designated HPSAs in Louisiana.

- **Primary Care:** In this designation type, the number of hours per week each primary care physician in the parish sees patients is compared to the number of possible patients in the area for a geographic designation. In Louisiana, most of the primary care HPSA designations meet the high needs criteria, which means the qualifying ratio of possible patients to physicians needed to be designated as a HPSA is 3,000 possible patients to one full-time physician. Non-priority areas require a ratio of 3,500:1 to qualify. There are also "Population Group" and "Facility" HPSAs in this category.

- **Mental Health:** In the mental health designation, the number of hours worked by psychiatrists is compared to the number of possible patients in the area most of the time. The criteria are met for high needs areas with a ratio of 20,000:1 for a geographic designation. Other non-high needs areas must meet a ratio of 30,000:1 to qualify. This category also includes the "Population Group" and "Facility" HPSAs.

- **Dental Health:** The dental health designation requires that the number of hours each dentist works, the age of the dentist and the number of dental assistants the dentist employs is taken into consideration and then compared to the number of possible patients in the area. The dental HSPA which meets the criteria requires a 4,000:1 ratio in a high needs area for a geographic designation. Other non-high needs areas need a ratio of 5,000:1 to qualify. "Population Group" and "Facility" HPSAs are also included in this category.

Eligibility Requirements

Eligible Health Professionals: The following health professionals are eligible to receive a SLRP award:

MD/DO	Doctors of Allopathic/Osteopathic Medicine – Family Practice (FP), General Practice (only those who have completed residency training), Internal Medicine (IM), Pediatrics (PD), Obstetrics/Gynecology (OB/GYN) and General Psychiatry
DDS/DMD	General Practice Dentists or Pediatric Dentists
NP	Primary Care Certified Nurse Practitioners
CNM	Certified Nurse-Midwives
PA	Primary Care Physician Assistants
RDH	Registered Clinical Dental Hygienists
HSP	Health Service Psychologist (Ph.D. or equivalent for Clinical and Counseling)
LCP	Licensed Psychologists (Clinical/Counseling Psychologists -Ph.D. or equivalent)
LCSW	Licensed Clinical Social Workers (Master's or Doctoral degree in Social Work)
PNS	Psychiatric Nurse Specialists
LPC	Licensed Professional Counselors (Master's or Doctoral degree with a major study in Counseling)
MFT	Marriage and Family Therapists (Master's or Doctoral degree with a major study in Marriage and Family Therapy)

Note: General practitioners (physicians who have not completed residency training programs) are not eligible for funding.

Eligible Health Professionals-the following criteria must be met by applicants to be eligible for SLRP funds:

- Professionals who are United States citizens/nationals must have a current license by the appropriate licensing agency to practice in Louisiana.

- Professionals must agree to serve a minimum of three years in a federally designated HPSA appropriate for their discipline.

- Professionals must work full-time (40 hours/week), with a minimum of 32 hours per week providing clinical services in an outpatient/ambulatory care setting located in a federally designated HPSA. There is an exception for obstetrics/gynecologists or nurse midwives who work at least 21 of those hours (per week) providing clinical services in an outpatient/ambulatory care setting. The professional must not have a work week that is compressed into less than 4 days per week. The professional shall not work more than 12 hours in any 24-hour period during their "regular" work week. Time spent on-call and travel time to a practice site will not count toward the 40 hours of work per week. Hours worked over the required 40 hours per week will not be applied toward any other work week.

- Professionals whose educational loans are from certified educational lenders, whether governmental or commercial, must have been incurred during completion of their education. Also, the loan funds must have been applied toward tuition, education, and reasonable living expenses for their own graduate/medical/undergraduate degrees.

- Professionals who have not breached a health professional service contract with the federal, state, or local government, or other entities.

- Professionals who have completely satisfied any other obligation for health professional service that is owed under an agreement with the federal government, state government, the local governing body, or other entities prior to the beginning of service under this program.

- Professionals who have not had a lien levied against their property for a debt to the United States government.

- Professionals who have not defaulted on their educational loans at any time, unless corrective actions have been made and loans are now in good standing. **Professionals must agree to share confidential information (name and social security number) with Louisiana Office of Student Financial Assistance (LOFSA) for the sole purpose of verifying loans are in good standing.**

- Professionals who have not had a debt "written off" as uncollectible [pursuant to 31 U.S.C. 3711(a)(3)], or had any federal service or payment obligation waived.

- Professionals under contract to work for a public and/or non-profit facility must agree to accept Medicare, all applicable Medicaid managed health plans, and to treat patients regardless of their ability to pay.

- Professionals must offer a sliding fee scale (i.e., a discount fee schedule) to low-income, un-insured and under-insured people; must provide care at no cost for those unable to pay and must not discriminate against individuals based on their ability to pay or the type of payment offered. The sliding fee scale used must be based on the federal poverty guidelines and apply to at least those who are at or below the most recent 200% federal poverty level. The poverty guidelines can be viewed at https://aspe.hhs.gov/poverty-guidelines. Professionals must charge the usual and customary prevailing rates for the area in which their professional services are provided. (See the following on how to develop a sliding fee scale: http://nhsc.hrsa.gov/downloads/discountfeeschedule.pdf). **The facility must have a posted sliding fee scale sign easily seen in the check-out area.** One (1) year of data for the site must be provided in order for the site to be eligible. This must be provided on the Louisiana SLRP Site Information Form by the facility at application and then updated at the end of the 2nd and 4th quarters throughout the duration of the contract. **The site is not eligible if this cannot be provided.**

- Individuals in the Reserve Component of the U.S. Armed Forces or National Guard.

- Professionals who are willing to spend no more than seven (7) weeks a year away from the practice site for vacations, holidays, continuing professional education, illness or any other reason; professionals with absences greater than seven (7) weeks in a service year must extend their service commitment date.

- Professionals who agree to use these funds to repay qualifying educational loans. Public Law 111-148, the Patient Protection and Affordable Health Care Act (HIPPA-A), makes payments under the National Health Service Corps Loan Repayment Program and certain State Loan Repayment Programs tax exempt from federal tax. Up to six percent (6%) of these funds can be set aside to pay for the professionals' Louisiana state income tax, however, **any funds not needed for taxes will be paid towards educational loans.**

- Professionals who are current on child support applications and those who are no longer in arrears with past child support payments.

- Professionals will be required to register as a vendor through Louisiana's LAGov system. This will require logging into the system and supplying your information to receive a purchase order (PO) number that will be used to track your contract. More instruction will be given to the applicants chosen.

Ineligible Health Professionals—the following are ineligible to receive a SLRP award:

- Non-citizens or non-nationals of the United States, including permanent resident aliens and other aliens.

- Professionals who have an outstanding contractual obligation to provide a health professional service to the Federal Government (e.g., an active military obligation, National Health Service Corps (NHSC) Loan Repayment Program, NHSC Scholarship Program, Nursing Educational Loan Repayment Program or Nursing Scholarship Program obligation), or a state or other entity, unless that service obligation will be completely satisfied before the SLRP contract has been signed. Be aware that certain bonus clauses in some employment contracts may impose a service obligation. If the

SLRP participant's military training and/or service, in combination with the participant's other absences from the service site, exceed 35 workdays per service year, the SLRP service obligation should be extended to compensate for the break in "full-time" service.

- Professionals who have breached an obligation for health professional service to the federal government, state government, or local government or another entity.

- Professionals who owe an obligation for health professional service to the federal government or a state government, or another entity under an agreement with such federal, state, or other entity is ineligible for the loan repayment program, unless the obligation will be completely satisfied prior to the beginning of this program.

- Professionals who are obligated under another loan or scholarship payback program, regardless of source. Once a person has fulfilled other obligations, that person may apply for a SLRP. Professionals applying must meet all other eligibility requirements for a period that begins after the other obligation(s) end.

- Professionals who are delinquent on their child support payment obligation.

- Professionals who have a judgment lien against their property for a debt to the United States.

- Professionals who have a loan(s) in default status at time of application.

- Physicians who have not completed residency training programs.

- Students or residents who are not licensed and able to work full-time at an approved HPSA site at the time they apply.

- Professionals who are not working full-time (40 hours per week) at a public and/or non-profit facility that treats everyone regardless of ability to pay.

Application Requirements and Priorities

Application Process Requirements

1. Submit an application along with other required forms and all necessary documentation between April 1, 2016 and June 30, 2016 in order to be considered for funding for the next federal grant cycle. Most contracts for that grant cycle will begin in October 2016 for this funding cycle.

   NOTE: Application submission does not guarantee funding. If total applicant need is greater than the amount of SLRP funding available, the SLRP priorities outlined in this policy will be used to determine which applicants will receive SLRP funds.

2. **All applications must include the following:**
    - **a copy of a current employment contract***;**
    - **a copy of the resume;**
    - **a copy of current professional license;**
    - **a copy of Louisiana Medicaid Provider Identification Number or a copy of the application for this number;**
    - **a completed Site Information Form;**
    - **proof of non-profit and/or public status of site;**
    - **a signed Agreement for all Participating SLRP Sites form;**
    - **a signed Attestation of No Other Obligation form;**
    - **a signed Certification Regarding Environmental Tobacco Smoke form;**
    - **a signed Consent for Release of Information Waiver of Confidentiality form;**
    - **a signed Release from Liability form;**
    - **documentation of employer's sliding fee scale (copy of scale in use along with the Sliding Fee Scale policy);**
    - **documentation of employer's sliding fee scale public notice signage;**
    - **IRS Form W-9;**
    - **Electronic Funds Transfer form with voided check; and**
    - **a valid copy of the current education loan statement with remaining principle balance showing.**

    ***For public employee(s), a letter of agreement with the governmental agency and verification of employment will be accepted in lieu of an employment contract.
    NOTE: A maximum of two professionals per practice site will be approved per grant year. If more than two professionals per site apply, the facility will be contacted for additional information in the funding decision regarding the professionals from that site.

3. Following notification of funding and receipt of the SLRP contract in the mail, the applicant should return the signed SLRP contract with the understanding that once the contract is signed by the Secretary of DHH, or his/her designee, and approved through the DHH contract approval process, the applicant is agreeing to accept repayment of his/her educational loans in exchange for providing outpatient primary care health care services for an agreed upon period of obligation in a federally designated HPSA.

    NOTE: Neither the applicant nor the State is bound by the contract until:
    a) The secretary of DHH, or his/her designee, has signed the SLRP contract; and
    b) The contract has been approved by the Louisiana Division of Administration, Office of State Procurement.

Priorities

Similar to the participant selection policies and procedures of the NHSC, the Louisiana SLRP will utilize the criteria described below to determine how individuals are selected to participate in the program. Review of applications received from April 1, 2016 through June 30, 2016 will occur in August with notifications of funding completed in September 2016. **Applying for this program does not guarantee automatic funding.**

NOTE: Most contracts will begin October 1, 2016 and will be prioritized according to the criteria requested in this application. Funding will continue until the total grant funds for the 2016 grant cycle are exhausted.

The following criteria will be considered as priorities when reviewing SLRP applications:

1. Priority will be given to applicants who work in facilities with the highest percentage of underserved patients, including those who have a Medicaid managed health plans and Medicare, those who are uninsured and indigent or underinsured and unable to find treatment. Some of these types of priority facilities would include public health units, Federally Qualified Health Centers and their satellite sites, School-Based Health Centers, state operated facilities or other eligible facilities which are subsidized by the state/federal government. A Louisiana SLRP Site Application Form must be completed at application [see attachment Section D – Practice (Work Location) Information] and after the 2nd and 4th quarters of every year of contract eligibility. This must include one (1) year of data for the site. **The site is not eligible if this cannot be provided.**

2. Priority will be given to individuals who agree to serve in HPSAs with the highest degree of shortage, rural, and whose service will have the greatest impact on underserved populations in these high-needs parishes (see maps of Louisiana HPSAs—Appendix E).

3. Priority will be given to individuals who agree to accept referrals and provide health care services to a significant portion, of at least 25% HIV/AIDS patient-base.

4. Priority will be given to applicants who agree to treat targeted populations who are designated as underserved in their service area, e.g. migrant farm workers, homeless, etc.

5. Priority will be given to individuals who will be available for service (to work full-time at an eligible facility) at the earliest dates.

6. Consideration will be given to an applicant's individual circumstances, such as the individual's cooperation, the placement site's cooperation and the loan obligations/ financial status of the individual.

7. **Applicants who submit incomplete application packets <u>will not be considered</u>.**

<u>Benefits for Participants</u>

Grant Award Amounts/Length of Contracts

Payments to obligated health professionals for remittance to educational loan creditors may receive:

a. Up to $30,000 annually (or the amount of the principle balance of the educational loan if less than the total eligible to receive) if the primary care physician, dentist, or psychiatrist agrees to work in an outpatient capacity at an approved facility for an initial period of three (3) years; OR

b. Up to $15,000 annually (or the amount of the principle balance of the educational loan if less than the total eligible to receive) if the primary care health care professional (all those eligible except physicians and dentists as noted on page 2) works in an approved facility for an initial period of three (3) years.

Participants, who complete their original commitment, continue to meet all criteria previously stated in this application, and who have additional educational loans may be considered for a

two-year extension for up to $24,000. The number of extensions offered annually will be limited. The number will be determined by the review committee annually after consideration of the program budget occurs. The SLRP participant's compliance with program requirements during their initial contract period will factor into the decision of this offer.

Taxable Income

Loan repayments are taxable by the Louisiana state income tax. Loan repayment funds of not more than six percent (6%) can be set aside to defray this income tax liability. Funds that were set aside that were not needed to pay the taxes on this money must then be applied to certified educational debt.

Disbursement of Funds

Funds will be disbursed to the contractor quarterly upon receipt of a quarterly service report. The quarterly service report will serve as both an invoice and a monitoring tool. These reports are due by the 15th of the month following the end of the quarter. Quarterly payments will be disbursed for the duration of the SLRP contract, as long as the contractor meets his/her service obligations under the terms of his/her contract and there is an unpaid loan balance.

Repayment of Loans

To enhance the provision of the health care services, the program will repay the governmental or commercial educational loans obtained by the health professional for:

1. Government and commercial loans for actual costs paid for tuition related to the undergraduate or graduate education of the participant leading to a degree in the health profession in which the participant will satisfy his/her SLRP service commitment;

2. Other reasonable educational expenses required by the health professional school, including fees, books, and laboratory expenses, incurred by the participant;

   NOTE: Reasonable educational expenses are the costs of education, exclusive of tuition, such as fees, books, supplies, clinical travel, educational equipment, and materials, which do not exceed the school's estimated standard student budget for educational expenses for the participant's degree program and for the year(s) of that participant's enrollment.

3. Reasonable living expenses will be determined by the SLRP office in accordance with published university standards. Health professional schools that make direct loans to their students are considered commercial lenders for the purposes of the program.

   NOTE: Reasonable living expenses are the costs of room and board, transportation, and commuting costs and other costs that do not exceed the school's estimated standard student budget for living expenses at that school for the participant's degree program and for the year(s) of that participant's enrollment.

Service Obligations

Following are the obligations which must be agreed upon by the health professional:

1. To serve a minimum of three (3) years with two (2) additional years possible;

2. To provide primary health care services at an eligible site, i.e., public and/or non-profit entity located in a federally designated HPSA that is appropriate for his/her discipline (i.e., primary care professionals must be placed in a primary care HPSA, dental professionals must be placed in dental HPSAs, and mental health professionals in mental HPSAs);

3. To be contracted with a pubic and/or non-profit facility that agrees to accept Medicare and any applicable Medicaid managed health plans; provide a sliding fee scale/discounted fee rate if a person is at or below current 200% of federal poverty level or is unable to pay the full charge and is uninsured. **Employer must post a sign in a conspicuous place in the waiting room of the practice that states, "We accept all patients regardless of ability to pay."**

4. To charge for their professional services at the usual and customary prevailing rates in the area in which such services are provided, except if a person is unable to pay such charges, such person shall be charged at a reduced rate (i.e., discounted/sliding fee scale) or not charged any fee;

5. To provide primary health services to any individual seeking care and agree not to discriminate on the basis of the patient's ability to pay for such care or on the basis that payment for such care will be made pursuant to Medicare (established in Title XVIII of the Social Security Act) or any applicable Medicaid health plan.

6. To accept assignment under Medicare (section 1842(b) (3) (B) (ii) of the Social Security Act) for all services for which payment may be made under Part B of Title XVIII;

7. To enter into an appropriate agreement with the State agency that administers the State plans for Medicaid under Title XIX to provide service to individuals entitled to medical assistance under the plan;

8. To provide health care services and encounters as defined below:

    - Provide full-time primary health care service or clinical practice in a public or non-profit private entity located in a current federally designated HPSA that is appropriate for their discipline (e.g., dental professionals must be placed in dental HPSAs, etc.). For physicians, the practice will include ambulatory care, as well as hospital care appropriate to meet the needs of patients and to assure continuity of care.

    - For all health professionals, "full-time clinical practice" is defined as a minimum of 40 hours per week of patient care at an approved service site, with no more than eight (8) of those hours per week devoted to practice-related administrative activities. The practice will include hospital treatment coverage appropriate to meet the needs of patients of the approved service site and to ensure continuity of care.

- With the exception of obstetrician/gynecologist (OB/GYN) physicians, family practice physicians who practice obstetrics on a regular basis, and/or certified nurse midwives (CNM), all health professionals must spend at least 32 of the minimum 40 hours per week providing direct patient care. These services must be conducted during normally scheduled clinic hours at the approved service site. The remaining hours must be spent providing inpatient care to patients of the approved site and/or in practice-related administrative activities.

- For OB/GYN physicians, family practice physicians who practice obstetrics on a regular basis, and CNMs, at least 21 of the minimum 40 hours per week must be spent providing direct patient care. These services must be conducted during normally scheduled clinic hours at the approved service site. The remaining hours must be spent providing inpatient care to patients of the approved site and/or in practice-related administrative activities, not to exceed eight hours per week.

- No more than seven (7) weeks (35 workdays) per year can be spent away from the practice for vacation, holidays, continuing professional education, illness, or any other reason. Absences greater than seven (7) weeks will extend the service commitment end date.

- The 40 hours per week may be compressed into no less than four (4) 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.

- Provide DHH with a signed quarterly service report for monitoring purposes, which states the number of hours worked and totals the number of encounters rendered. The report also shall stipulate the number of encounters for each of the following types of patients: Medicare, all applicable Medicaid managed health plans, Sliding Fee Scale/Discounted Fee, and Uninsured/Unable to Pay, AND the following, if these patients were a factor in the amount of award received or initial funding in the program: HIV/AIDS, Substance Abuse, Homeless, Migrant, and Elderly (65 and over). **One (1) year of data for the site must be provided in order for the site to be eligible.** This must be provided for the facility at application and then updated at the end of the 1st and 3rd quarters throughout the duration of the contract. **The site is not eligible if this cannot be provided.**

9. Submit to DHH a copy of the appropriate loan statement, which shows the current principle balance of the loan(s), by April 15th and October 15th of each year.

10. Notify the Bureau of Primary Care and Rural Health of any changes in status. This may include, but is not limited to, changes in mailing address, phone number, employment, employer policies related to target patient type, loan default status, and licensure status.

NOTE: The contractor MUST have written approval from the LA DHH Bureau of Primary Care and Rural Health before relocating to another employment site.

Service Site Requirements

Participating in Louisiana SLRP requires the provision of full-time clinical services at an eligible SLRP service site for the period agreed upon in the program contract. These sites are specific health care practice opportunities identified by the SLRP in certain federally designated HPSAs that have experienced special difficulty recruiting or retaining health professionals because of the site's geographic isolation, severe economic need, or the chronically poor health status of the population to be served.

Approval of SLRP contracts is contingent upon verification that the service site accepts all applicable Medicaid managed health plans, Medicare, and sliding fee scale/discount fee patients. The site must also provide proof of non-profit/public status to the applicant for inclusion in the SLRP application. This can be done using the IRS form 501(c)3 form or Board Resolution Statement.

Compensation During Service

SLRP participants shall negotiate their compensation packages (salary and fringe benefits) directly with the service sites. The amount of funding received through SLRP should not be considered by the employer when negotiating the professional's compensation package.

Loan Information

Documenting Loans

Applicants must provide lender information and a copy of loan statement(s) with current balance along with their application. The most current principle balance of each educational loan should be determined as accurately as possible and reported by the applicant on the application form. The applicant should not include loans that have been paid off.

Consolidated and Refinanced Loans

Program participants may select from their qualifying loans those they wish to have included for repayment by the program, based on what they consider most advantageous. If an applicant has consolidated or refinanced loans, the applicant must provide a copy of the original loan documentation to establish the educational purpose and contemporaneous nature of such loans. **If an eligible educational loan is consolidated or refinanced with any debt other than another eligible educational loan of the applicant, no portion of the consolidated or refinanced loan will be eligible for loan repayment.**

Financial Obligations Not Qualifying For Repayment

Loans with no supporting documentation and/or loans not obtained from a government entity or certified commercial educational lending institution, e.g., loans from friends and relatives or credit card debt, are not qualified for repayment by the program.

Breaching the Loan Repayment Contract Agreement

Effects of Breaching the Contract

DEFAULT: SLRP Contractors who fail to begin or complete his/her SLRP service obligation, or otherwise breach the terms and conditions of the obligation, are in default of his/her contract and are subject to the financial consequences outlined below in this attachment. Examples of default are:

- Failure to begin or complete service term
- Failure to accept any applicable Medicaid managed health plans, Medicare assignment or implement a sliding fee schedule for low-income, uninsured people
- Failure to provide documentation of qualifying loans upon request/demand
- Failure to apply SLRP funds to either (a) the repayment of qualifying educational loan balances or (b) the State income tax owed on the SLRP payments disbursed through this contract, up to the six percent (6%) of the contract amount
- Failure to maintain eligibility as a Medicaid or Medicare provider

If a health professional is unable to complete the service obligation at the initial placement, assistance will be provided to find another eligible placement. If a contractor chooses not to find and accept a placement transfer/reassignment, then DHH must place the Contractor in default of the SLRP contract.

Financial Consequences

If the Contractor breaches a SLRP obligation, the contractor will be subject to pay an amount equal to the sum of the following:

- The total amount paid by the SLRP to, or on behalf of, the participant for loan repayment for any period of obligated service not served;
- An amount equal to the number of months of obligated service not completed multiplied by $7,500;
- Interest on the above amounts at the maximum legal prevailing rate, as determined by the treasurer of the United States, from the date of breach.

NOTE: The minimum amount that the Louisiana DHH is entitled to recover will not be less than $31,000.

Cancellations, Waivers, Bankruptcy, Suspensions and Defaults

The only permissible basis for canceling a SLRP contract is the death of the SLRP participant. States cannot cancel a SLRP contract in order to allow an individual to participate in the NHSC LRP or for any other reason except the participant's death.

Waiver of the SLRP obligation is a permanent status. In order to qualify for a waiver of the

SLRP obligation, a participant must document a medical condition or a personal situation that makes compliance with the obligation permanently impossible or an extreme hardship, such that enforcement would be against equity and good conscience. The documentation of this medical condition or personal situation will be reviewed by the Secretary of the Louisiana DHH. The Secretary is the only one who can grant a waiver of the SLRP obligation.

Suspensions of the SLRP contract obligations may be made for up to one year in the event of temporary physical or mental disability of the contractor or other justifiable causes. Documentation of the medical condition or personal situation which would make completion of the obligation temporarily impossible or an extreme hardship, such that enforcement would be against equity and good conscience, would be presented to the Secretary of DHH. The Secretary is the only one who can grant a suspension of the SLRP obligation.

Defaults occur when participants fail to begin or complete their SLRP service obligation or otherwise breach the terms and conditions of the obligation. Participants who are in default of their contracts are subject to the financial consequences outlined in their contracts and in this policy in the prior section entitled *Financial Consequences*.

Application Information

General Application Information

Participants must complete a SLRP application form giving all information requested in the application. Applications must be submitted between April 1, 2016 and June 30, 2016 in order to be accepted. Applications will be reviewed in August. Notifications of funding status will be sent by September 30, 2016. Most contracts will start October 1, 2016. The application should also include all the additional forms requested in the application and in this policy to be considered complete (see list following the application submission address). **Incomplete application packets submitted will not be considered.**

Application Submission Address

The completed application must be submitted to the LA Department of Health and Hospitals at the following address:

Attn: Beth Butler
LA DHH Bureau of Primary Care & Rural Health, 8th floor
P.O. Box 3118
Baton Rouge, LA 70821.3118

Application Review Checklist

The fully completed, signed application must be submitted along with the following forms and information:

- ⎯ Copy of executed employment contract for length of years requesting SLRP participation, OR a letter verifying employment, if an employment contract is not available
- ⎯ Resume
- ⎯ Copy of current professional license
- ⎯ Documentation of the current principle balance of the applicant's certified educational debt. This should include name and account number for each loan
- ⎯ Signed *Agreement for All Participating SLRP Sites Form*
- ⎯ Signed and **notarized** *Attestation of No Other Obligation Form*
- ⎯ Signed *Certification Regarding Environmental Tobacco Smoke Form*
- ⎯ Signed *Release from Liability Form*
- ⎯ Signed *Consent for Release of Information Waiver of Confidentiality Form*
- ⎯ Documentation of employer's sliding fee scale/discount fee policy
- ⎯ Documentation of employer's sliding fee scale/discount fee schedule- actual scale
- ⎯ Photo of employer's sliding fee scale/discount fee policy posted in the checkout/lobby
- ⎯ Photo of employer's sign posted in the checkout/lobby that states **"We accept all patients regardless of ability to pay."**
- ⎯ Copy of current *Louisiana Medicaid Provider ID Number* or a copy or application for this number
- ⎯ Completed *IRS Form W-9-Request for Taxpayer ID Number* that matches applicant address
- ⎯ Completed *Electronic Funds Transfer Form* **with** voided blank check
- ⎯ Signed completed *Site Information Form.* <u>The information on this form must be compiled with one complete year of data.</u>
- ⎯ Proof of site's non-profit and/or public status

<u>Contract Information</u>

The process to be used by the State to obligate individuals is best described as the negotiation of a professional services contract, or a social services contract depending on the type of professional applying. The terms of the contract will indicate that the services to be provided are primary, dental or mental health care services in an approved federally designated HPSA. In return, DHH will provide reimbursement for valid educational loan debts. Loan repayment benefits are taxable income by the State of Louisiana. A Form 1099 will be issued each January to loan repayment participants.

Service Report Information

SLRP participants are required to complete a *Quarterly Service Report Form* by the 15th of the month following the end of the quarter. It can be submitted by mail to DHH, Bureau of Primary Care and Rural Health, Bienville Building 8th Floor, Beth Butler, Program Coordinator, P.O. Box 3118, Baton Rouge LA 70821.3118, or faxed to 225.342.5839, or scanned and emailed to beth.butler@la.gov. The participant must also send loan statements verifying payments made with the Quarterly Service Reports for the 1st and 3rd quarters. Submitting this information after the due dates will delay the issuance of a participant's reimbursement and could be grounds for refusal of payment, especially at the end of the state fiscal year in June.

SLRP Contact Person and Contact Information

LA Dept. of Health and Hospitals
Beth Butler, Program Coordinator
Bureau of Primary Care and Rural Health, Bienville Building, 8th floor
628 North 4th Street or PO Box 3118
Baton Rouge, LA 70821.3118
Office: 225.342.4702
Fax: 225.342.5839
E-mail: beth.butler@la.gov

Appendices

Appendix A Health Professional Application for Loan Repayment Program

Appendix B Supporting Documentation and Forms

(1) *Agreement for All Participating SLRP Sites Form*

(2) *Attestation of No Other Obligation Form*

(3) *Certification Regarding Environmental Tobacco Smoke Form*

(4) *Release from Liability Form*

(5) *Consent for Release of Information Waiver of Confidentiality Form*

(6) *IRS Form W-9—Request for Taxpayer ID Number*

(7) *Electronic Funds Transfer Form*

(8) *Site Information Form*

Appendix C Sample Contract

Appendix D Sample Sliding Fee Scales

Appendix E Maps—check the Web site for current maps:
http://new.dhh.louisiana.gov/index.cfm/page/570/n/252

(1) Health Professional Shortage Area Maps
- (a) Primary Care
- (b) Dental Health
- (c) Mental Health

Appendix A- Health Professional Application for Loan Repayment Program

DEPARTMENT OF HEALTH AND HOSPITALS

APPLICATION FOR LOUISIANA STATE LOAN REPAYMENT PROGRAM (REV. 04/13)

Section A - Personal Data

1. Applicant Name: _____

2. Social Security Number or TIN: _____

3. Home Address: _____

_____

4. Mailing Address (if different from Home): _____

_____

5. Main Phone Number: _____

6. Alternate Phone Number: _____

7. E-mail: _____

8. Date of Birth: _____

9. Are you a U.S. citizen/national? ☐ Yes ☐ No

10. City and State of Birth: _____

Questions 11 - 14 are optional and are needed for federal/state reporting purposes.

11. Race/Ethnicity—please check one. ☐ White ☐ Black ☐ Native American ☐ Asian ☐ Hispanic

12. Did you participate in an Area Health Education Center health career program? ☐ Y ☐ N

13. Did you grow up in Louisiana? ☐ Y ☐ N

If yes, in a rural area (under 25,000 population)? ☐ Y ☐ N

Section B - Health Profession Choice and Education

1. Health Profession (choose one):

- ☐ M.D.-Family Medicine
- ☐ M.D.-General Internal Medicine
- ☐ M.D.-OB/GYN
- ☐ General Dentistry (DDS or DMD)
- ☐ Pediatric Dentist
- ☐ M.D.-Psychiatrist
- ☐ Primary Care Physician Assistant
- ☐ P. C. Certified Nurse Practitioner
- ☐ Psychiatric Nurse Specialist
- ☐ M.D.-Pediatrician
- ☐ M.D.-IM (with sub-specialty training)
- ☐ Certified Nurse Midwife
- ☐ Licensed Dental Hygienist
- ☐ Health Service Psychologist
- ☐ Licensed Clinical/Counseling Psychologist
- ☐ Licensed Clinical Social Worker
- ☐ Licensed Marriage and Family Therapist
- ☐ Licensed Professional Counselor

2. Educational Information:

Undergraduate Degree: _____ Graduation Date:_____

Undergraduate School Name/Location: _____

Graduate Degree: _____ Graduation Date: _____

Graduate School Name/Location: _____

Medical/Dental School Specialty: _____ Graduation Date:_____

Medical/Dental School Name: _____

Medical/Dental School Address (City, State, Zip): _____

Residency Program Specialty Type: _____Start and End Dates: _____

Residency Program Location (City, State, Zip): _____

Fellowship Program Specialty Type: _____Start and End Dates: _____

Fellowship Program Location (City, State, Zip): _____

3. Are you (check if applicable) Board Certified? ☐ Board Eligible? ☐

4. Louisiana License Number: _____ Date Issued: _____

5. National Provider Identifier (NPI) Number: _____

6. Medicare Identification Number: _____

7. Medicaid Identification Number:_____

Section C - Educational Debt—List below, in priority order, the first four educational loans received during undergraduate and graduate professional study. **Educational loans considered part of this loan repayment plan may be consolidated—but not with other non-educational loans.** Current loan balance statements must be submitted with this application.

Loan 1—Loan Program Name and Address:	Account Number:_____ Current Principle Balance:_____ Academic period covered by loan:
Loan 2—Loan Program Name and Address:	Account Number:_____ Current Principle Balance:_____ Academic period covered by loan:
Loan 3—Loan Program Name and Address:	Account Number:_____ Current Principle Balance:_____ Academic period covered by loan:

1. Applicant agrees to provide outpatient primary care for three (3) years—check to verify □Yes

2. Are any of the loans listed above or any other part of your medical education being repaid through another loan repayment program? □ No □ Yes

   If yes, please provide the name of the loan repayment program:

_____

3. Are any of the loans listed above or any part of your medical education being repaid through any type of service obligation? □ No □ Yes

   If yes, please provide the name and address of entity to which the obligation is owed:

_____

   Has this obligation been satisfied? □ No □ Yes (if yes, attach documentation)

   Date obligation was repaid: _____

4. Are you now or have you ever been declared in default on any educational loans? □ No □ Yes

   If yes, please explain: _____

_____

5. Are you now or have you ever been declared in default/breach of any federal contract/agreement or health care service agreement/obligation? □ No □ Yes

   If yes, please explain: _____

_____

6. Are you responsible for making Child Support payments? □ Yes □ No Are you current with these payments? □ Yes □ No If no, please explain: _____

7. Is there an Income Assignment Order in place for Child Support Payments? □ Yes □ No

8. The Bureau of Primary Care and Rural Health checks defaulted student loan status by providing LOFSA with each applicant's name and social security number. The information is provided in a password protected spreadsheet. Do you give the Bureau permission to share this information with LOFSA? □ Yes □ No

Section D – Practice (Work Location) Information-Please include 1 year of cumulative data.

LOUISIANA SLRP SITE INFORMATION FORM

	OFFICE USE ONLY-DATE REC'D:
Name and Address of Practice Site:	Name and Address of Employer (if different):
Contact Name and Title: Contact E-mail: Contact Telephone: Contact Fax:	Telephone Number at Practice Site: Fax Number at Practice Site: Employer's telephone: Employer's fax:
Type of Practice: □ Public □ Non-profit □ Both **(provide proof of checked practice type with application)** Type of Facility: □ FQHC □ RHC □ Private □ State □ other _____	Employer's Medicaid ID#: Employer's Medicare ID#
What is the SLRP Clinician's routine work schedule? Include office hours, hospital privileges, call coverage, duties, patient load and an explanation of any special work related responsibilities for the position.	
How many patients were seen at this location last year?	How many of these patients were uninsured?
How many of these patients were in Medicaid managed health plans?	How many of these patients were Medicare?
Does this practice site currently have in place a sliding fee scale/indigent care policy for patients below 200% of the Federal poverty level? □ YES □ NO If yes, what percentage of uninsured patients was eligible for reduced fees last year? When was the policy established? _____ When was the policy last updated? _____ Are signs posted to inform patients of this policy? □ Yes □ No **(provide examples of signage/notices in place)**	
Besides posted signs, how does the site ensure that patients are aware of the availability of the sliding fee scale/indigent care policy? Please give details and samples if applicable.	
IMPORTANT NOTE: The applicant will be notified of the decision whether or not to support this request by the end of September. The clinician's contract for SLRP will not begin until October 1, 2016 if the clinician is awarded funds. For additional information, contact Beth Butler at 225.342.4702 or beth.butler@la.gov .	
Signature:	Date Application Mailed:

NOTE: A COPY OF YOUR EMPLOYMENT CONTRACT MUST BE INCLUDED WITH THIS APPLICATION.

Section E - Other Information about the Louisiana State Loan Repayment Program

1. Any individual who owes an obligation of professional health care service to the federal government, any other state government agency or any other entity under an agreement with said entity is ineligible to receive payment under this program until obligation has been completely satisfied. This obligation must be satisfied prior to beginning service under this program.

2. The following forms, with original signatures, must be included with this application: *Agreement for All Participating SLRP Sites Form*; *Attestation of No Other Obligation Form* (complete all sections and have form notarized); *Certification Regarding Environmental Tobacco Smoke Form*; *Release from Liability Form*; *Consent for Release of Information and Waiver of Confidentiality Form*; and *Site Information Form*. These can be found on pages 26-34 of this guidance.

3. State Loan Repayment Program funds are not taxable by the federal government. However, these funds are **TAXABLE** by the State of Louisiana. You will receive a Form 1099 from the LA Department of Health and Hospitals each year you receive funds through the program. You are allowed to withhold 6% of monthly payments to pay state income taxes. Whatever is not paid on taxes will be applied to your educational loan.

4. Every April and October of each SLRP contract year, you will be responsible to verify the balance of your loans by sending the State Loan Repayment Program Monitor a copy of your current educational loan principle balance. You are required to submit the Site Information Form at this time as well.

5. Each quarter that you are eligible for assistance through the State Loan Repayment Program you must submit a quarterly report of your practice activities. This report acts as your invoice for that quarter's loan repayment assistance. **These reports are due by the 15th of the month following the reporting quarter. If these reports are not received by the 15th of the following month, the state reserves the right not to honor that quarter's payment.** Allow 3 weeks from the 15th of the month following the end of the quarter for your payment to be issued.

6. Application for participation in the Louisiana SLRP does not guarantee that funds will be available. If the applicants' total needs are greater than the amount of SLRP funds available, the SLRP Priorities as described in the SLRP Policy will be used to determine which applicants will receive SLRP awards.

CERTIFICATION: In signing and returning this application to the Louisiana LA Department of Health and Hospitals (DHH) Bureau of Primary Care and Rural Health, I hereby certify that I have read and understand the information contained in this application and the entire Louisiana State Loan Repayment (SLRP) policy. I also certify that as indicated by my signature below, I am in agreement with the terms and conditions set forth in this application and in the SLRP policy, including the terms of waivers, suspensions, cancellations, defaults, and repayments. I also certify that I will review all the terms of the SLRP contract if I am awarded funding, including the dates of the contract period. I am also indicating that I am in agreement with completing my service obligation to meet the conditions of the SLRP contract, as outlined in the SLRP policy. These conditions will be outlined in the contract and its Attachments 1-7 also. I am affirming that all statements made by me during this application process are complete and accurate to the best of my knowledge. I am indicating by my signature my agreement to participate in this program by entering into an agreement in the form of a contract with Attachments 1-7 with Louisiana DHH for repayment of my educational loans, which are listed in Section C of this application, in exchange for my services.

These services will be provided as outlined in the SLRP contract and in Attachment 1 of the contract, if I am approved for funding and my SLRP contract is approved. I understand that returning this application does not mean automatic approval. I am aware that if the applicants' needs for this application period exceed the amount of funding available, the applications will be funded according to the priority facility list found in the SLRP policy, as well as the priority placed by the review committee. I also understand that if I am awarded funding, a contract will be mailed to me for my review/signature. I understand that the contract will not be in effect until it is returned to DHH and approved by the Division of Administration, Office of State Procurement. I also understand that once final approval has been granted, all terms and conditions of the contract will be in full effect and binding for me and the State of Louisiana, including the terms of default, as outlined in the Louisiana SLRP Policy and in Attachments 3 and 4 of the SLRP contract.

Applicant Signature

Date

Appendix B— Supporting Documentation and Forms

(1) Agreement for All Participating SLRP Sites Form

DEPARTMENT OF HEALTH AND HOSPITALS

AGREEMENT FOR ALL PARTICIPATING SLRP SITES

We, _____

Practice Site Name and Address

Read each statement below and initial as to your compliance with the SLRP regulations.

— Use a sliding fee schedule and/or other documentable method to reduce fees that assures no financial barriers to care exist for people who are at or below 200% of federal poverty level with no insurance. We also accept assignment of Medicare patients and those enrolled in Medicaid managed health plans.

— We prominently post a sign that states, "We accept all patients regardless of ability to pay."

— We do not discriminate based upon race, color, sex, national origin, disability or religion.

— We provide culturally appropriate ambulatory primary care, dental and/or mental health services.

— We use a credentialing process which, at a minimum, includes reference review, licensure verification and a query of the National Practitioner Data Bank of those clinicians for whom the NPDB maintains data.

— We adhere to sound fiscal management policies and adopt clinician recruitment and retention policies to help the patient population, the site and the community obtain maximum benefits.

— We will pay SLRP clinicians a salary and benefit package, including professional liability coverage, at least equal to any that would be offered to any other comparably trained and experienced clinician. The package we offer the SLRP employee will not factor-in the SLRP funding the employee is receiving.

— We currently require SLRP clinician(s) to maintain a full-time (40 hours/week- unless OB/Gyn or Certified Nurse Midwife) practice, a minimum of 32 of those hours being available to patients in an outpatient setting, for at least 45 weeks per year.

— We will communicate to the SLRP any change in site or clinician status that might adversely affect the site or clinician continuing an established relationship with the Louisiana State Loan Repayment Program.

— We will maintain and make available for review by SLRP representatives, all personnel and practice records associated with a SLRP clinician, including documentation which contains information that DHH may need to determine if the clinician has complied with criteria.

Signature below is assurance that this application contains true and correct information and that the site agrees to comply with all of the above requirements of this agreement.

Name of Site Official: _____

Signature of Site Official: _____Title:_____ Date: _____

Appendix B— Supporting Documentation and Forms
(2) Attestation of No Other Obligation Form

DEPARTMENT OF HEALTH AND HOSPITALS

ATTESTATION OF NO OTHER OBLIGATION

I, _____, hereby declare and certify, under penalty of the authority of
Applicant's Name
Section 338 of the Public Health Service Act (42 USC 254-1), that I am not under any obligation from any other loan, scholarship or contract involving any stipend, allowance or any other incentive to provide health professional service to the federal government, a State or local government, an employer or any other entity, unless such obligation is completely satisfied prior to the beginning of this contract with the Louisiana State Loan Repayment Program.

_____ _____
Applicant's Signature **Date**

****

I, _____ of _____ Parish hereby declare and certify, under
Applicant's Name **Parish of Residence**

penalty of the authority of Section 338 of the Public Health Service Act (42 USC 254-1), that

_____ has not offered _____ any loan, scholarship or
Applicant's Employer **Applicant's Name**

contract involving any stipend, allowance or any other incentive to provide health professional service to

the residents of _____ Parish unless such obligation has been completely satisfied prior
Parish of Employment

to the beginning of this contract for the Louisiana State Loan Repayment Program.

Signed or attested before me this _____ day of _____.

_____
Notary Public

Appendix B— Supporting Documentation and Forms
(3) Certification Regarding Environmental Tobacco Smoke Form

DEPARTMENT OF HEALTH AND HOSPITALS

CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood developmental services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through State or local governments, by federal grant, contract services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid managed health plans; or facilities where WIC coupons are redeemed. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing this certification, the offeror/contractor (for acquisitions) or applicant/grantee (for grants) certifies that the submitting organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The submitting organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

_____ _____

Signature of Organization Representative **Title**

_____ _____

Organization Name **Date**

Appendix B— Supporting Documentation and Forms
(4) Release from Liability Form

DEPARTMENT OF HEALTH AND HOSPITALS

RELEASE FROM LIABILITY

I, _____, hereby release from liability the Louisiana
Applicant's Name
Department of Health and Hospitals, its Secretary, Director, agents and employees for acts performed in good faith without malice in connection with evaluation of my application, credentials and qualifications, and hereby release from liability any and all individuals and organizations, who, in good faith and without malice provide information to the Department of Health and Hospitals or to its authorized representatives concerning my professional competence, ethics or character. I further release from liability the Louisiana Department of Health and Hospitals, its Secretary, Director, agents and employees for the delivery of information to any third party as authorized herein.

_____ _____
Applicant's Signature **Date**

_____ _____
Witness **Date**

_____ _____
Witness **Date**

Appendix B— Supporting Documentation and Forms
(5) Consent for Release of Information Waiver of Confidentiality Form

DEPARTMENT OF HEALTH AND HOSPITALS

CONSENT FOR RELEASE OF INFORMATION AND WAIVER OF CONFIDENTIALITY

I, _____, understand that the following information contained in my
Applicant's Name

records may or may not be confidential. However, I give my consent for

_____ to release to the Louisiana Department of Health
Certified Educational Lender

and Hospitals information regarding my educational loan(s).

The information is to be disclosed for the specific purpose of applying for repayment of the loan(s) under the Louisiana State Loan Repayment Program for health care professionals. This consent is deemed to be continuous unless revoked by me in writing.

_____ _____
Applicant's Signature **Date**

_____ _____
Witness **Date**

_____ _____
Witness **Date**

Appendix B— Supporting Documentation and Forms
(6) IRS Form W-9—Request for Taxpayer ID Number

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▸ .....

☐ Other (see instructions) ▸

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▸ **Date** ▸

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,
- The U.S. grantor or other owner of a grantor trust and not the trust, and
- The U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS a percentage of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Also see *Special rules for partnerships* on page 1.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account, for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your income tax return. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your income tax return on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name/disregarded entity name" line.

Partnership, C Corporation, or S Corporation. Enter the entity's name on the "Name" line and any business, trade, or "doing business as (DBA) name" on the "Business name/disregarded entity name" line.

Disregarded entity. Enter the owner's name on the "Name" line. The name of the entity entered on the "Name" line should never be a disregarded entity. The name on the "Name" line must be the name shown on the income tax return on which the income will be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a domestic owner, the domestic owner's name is required to be provided on the "Name" line. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on the "Business name/disregarded entity name" line. If the owner of the disregarded entity is a foreign person, you must complete an appropriate Form W-8.

Note. Check the appropriate box for the federal tax classification of the person whose name is entered on the "Name" line (Individual/sole proprietor, Partnership, C Corporation, S Corporation, Trust/estate).

Limited Liability Company (LLC). If the person identified on the "Name" line is an LLC, check the "Limited liability company" box only and enter the appropriate code for the tax classification in the space provided. If you are an LLC that is treated as a partnership for federal tax purposes, enter "P" for partnership. If you are an LLC that has filed a Form 8832 or a Form 2553 to be taxed as a corporation, enter "C" for C corporation or "S" for S corporation. If you are an LLC that is disregarded as an entity separate from its owner under Regulation section 301.7701-3 (except for employment and excise tax), do not check the LLC box unless the owner of the LLC (required to be identified on the "Name" line) is another LLC that is not disregarded for federal tax purposes. If the LLC is disregarded as an entity separate from its owner, enter the appropriate tax classification of the owner identified on the "Name" line.

Other entities. Enter your business name as shown on required federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name/ disregarded entity name" line.

Exempt Payee

If you are exempt from backup withholding, enter your name as described above and check the appropriate box for your status, then check the "Exempt payee" box in the line following the "Business name/ disregarded entity name," sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

The following payees are exempt from backup withholding:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 15.

IF the payment is for . . .	**THEN the payment is exempt for . . .**
Interest and dividend payments	All exempt payees except for 9
Broker transactions	Exempt payees 1 through 5 and 7 through 13. Also, C corporations.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt payees 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney, and payments for services paid by a federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on page 2), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, below, and items 4 and 5 on page 4 indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on the "Name" line must sign. Exempt payees, see *Exempt Payee* on page 3.

Signature requirements. Complete the certification as indicated in items 1 through 3, below, and items 4 and 5 on page 4.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner [3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulation section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity [4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulation section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 1.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, social security number (SSN), or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov*. You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

[1]

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Appendix B— Supporting Documentation and Forms
(7) Electronic Funds Transfer Form

BOBBY JINDAL
GOVERNOR

KRISTY H. NICHOLS
COMMISSIONER OF ADMINISTRATION

State of Louisiana

Division of Administration

Office of Statewide Reporting and Accounting Policy

A MESSAGE FROM THE DIRECTOR:

The State of Louisiana sends Electronic Fund Transfers (EFTs) from the State's bank directly to the payee's bank each weekday. However, checks are printed and mailed only on Tuesdays and Fridays of each week, except for holidays. **Electing to receive payments through EFT can result in you receiving your payments sooner.**

The only requirement for participation in the EFT payment process is that you have an active checking or savings account at a financial institution that can accept Automated Clearing House (ACH) credit files and remittance information electronically. Payees that elect to receive payments via EFT will not be sent paper remittance advices. This information will be transmitted electronically to the financial institution receiving these funds on your behalf. The remittance information sent electronically will mirror the information currently printed on check stubs. Remittance information includes: Issuing agency name, telephone number, agency number, document number, reference document number, invoice number, comments, and payment amount.

The State of Louisiana currently provides you with remittance information through the Internet. This Web based application is secured and presents detailed information about payments made from the State's central accounting system (ISIS). You have the ability to search for and view payment information for the most recent three years. **This site is useful for payments received by check and by EFT**.

Access to the application is via a LOG IN screen where the user must provide a valid taxpayer identification number (TIN - FEIN or SSN). The site is organized with you in mind and navigation is logical and simple. Popup help text is also available on selected fields. Availability of popup help text is signified by a question mark when you move the cursor over an item. It is accessible through OSRAP's Homepage at **http://www.doa.louisiana.gov/osrap** by clicking on the **Find Payments** button.

The following information should be verified by your bank to guarantee you are eligible for this process. The EFT payment will be transmitted using a CTX entry in ASCX12 Interchange Control Structures (ANSI ASC X12.5), Application Control Structure (ANSI ASC X12.6) and ANSI ASC X12 transactions containing the 820 Transaction Set (ANSI ASC X12.4). The 820 Transaction Set will contain your remittance information. **Your financial institution must have the ability to receive remittance information electronically and agree to provide that information to you upon request. Ensure that you specifically ask if they can provide you with the information found in the 820 Transaction Set. If you desire the receipt of remittance information as EFTs are received, you must specifically request your financial institution to provide it to you.**

By signing the attached form, you agree to receive your remittance information through your bank. You will be responsible for any fees assessed by your financial institution for this service. Please note that all payments made by the State of Louisiana to the location specified will be

made through EFT regardless of the agency requesting payment. Therefore, it is critical that you receive your remittance advices from your financial institution in a user-friendly format. If upon receipt of the remittance information, you have questions regarding a payment, you should contact the agency whose telephone number is provided.

Activation of your EFT enrollment will occur within 5 to 10 days from the time we receive your completed application form. After your enrollment has been activated, payments to you will be sent electronically in the normal course of business, unless we are notified otherwise, in writing.

If changes occur that affect your bank or account information after submitting the enrollment form, contact our office immediately at the telephone number or address listed below. Failure to do so may result in lost payments. The State will bear no responsibility for lost or misdirected payments if it is determined that you failed to notify us of changes or failed to provide correct information.

The State must identify payments to vendors via Electronic Funds Transfer (EFT) that are forwarded by the vendor to an account outside of the United States in order to comply with requirements of the United States Treasury Office of Foreign Assets Control. The rules are referred to as "International ACH Transaction (IAT) rules." ACH refers to Automated Clearing House transactions, the common name given to EFT transactions. In this case, IAT refers to the bank code used to identify the international ACH transactions. **You must check yes or no before the EFT Enrollment Form can be processed. Yes** means receipts are transferred to an account outside of the U.S. **No** means receipts are not transferred to an account outside of the U.S.

If you would like to continue receiving your payments in the form of a check, you do not need to respond. If you choose to receive your payments via EFT, the enclosed form must be completed and signed by an authorized individual within your organization and financial institution. Enrollees must agree to all of the conditions on the enrollment form. Any questions from our office will be directed to the individuals listed on the form.

For your convenience, an enrollment form and the instructions are enclosed. Completed forms and a copy of a voided check should be mailed or faxed directly to the address below. **For confidentiality reasons, do not return this form to any State agency other than the Office of Statewide Reporting and Accounting Policy (OSRAP).** If you have any questions, please contact OSRAP at:

LA Division of Administration
Office of Statewide Reporting and Accounting Policy
P.O. Box 94095
Baton Rouge, LA 70804-9095

OSRAP Help Desk:
Phone (225) 342-1097
FAX (225) 342-0964

I hope you will take advantage of this payment method.

Sincerely,

Afranie Adomako, CPA
Director

COMPLETING THE ENROLLMENT FORM

You are to complete the unshaded portions of the enrollment form. Please complete the fields with the following information:

Vendor Name - The name of your company or organization as it appears on the bank account referenced.

Please Check One – Select New Enrollment or Change.

Vendor Address - The mailing address of your organization to which all payments are sent.

NOTE: If this address is different from the address on your check, please explain the differences on a separate sheet and attach it to the EFT form.

Vendor FEIN/SSN - The Federal Tax Identification Number or Social Security Number of your organization.

ACH Routing Number - The 9 digit routing code of the financial institution for the specified savings or checking account to which funds will be deposited. If funds are deposited into your checking account, the routing number usually precedes your checking account number on the bottom of your checks.

Check/Savings Indicator - Circle the appropriate letter. "C" denotes a checking account and "S" denotes a savings account.

Bank Account Number - The bank account to which funds are to be deposited.

Bank ACCT DESCR - A general description of the bank account. For example, "Company XYX corporate checking account."

Bank Name - The name of the financial institution to which funds will be deposited.

Bank Address – (lines 1 – 3) - The mailing address of the financial institution to which funds will be deposited.

City/State/Zip - The Bank's City/State/Zip for the mailing address listed.

Bank Telephone Number - The telephone number of the branch or bank office to contact for assistance with transmission problem resolution.

International ACH Transactions – Check the appropriate box. **Yes** means receipts are transferred to an account outside of the U.S. **No** means receipts are not transferred to an account outside of the U.S. A box must be checked before the EFT enrollment form can be processed.

Vendor's Authorized Signature - The signature of the individual completing this form (Payee).

Print Name - Print or type the name of the individual completing this form.

E-mail Address - The e-mail address of the company or the individual completing this form. If applicable, you can enter an e-mail address that is different from the one listed above.

Date - The date the form is completed.

Phone Number - The telephone number of the individual completing the form.

NOTE: A representative from your financial institution must complete and sign the area at the bottom of the form. Please include a copy of a voided check, deposit slip, bank statement or a letter from your financial institution for depository accounts as verification of account information. This document must be pre-printed with the vendor's name and address – temporary checks or deposit slips are NOT acceptable.

ELECTRONIC FUNDS TRANSFER ENROLLMENT FORM		* **Please review instructions before completing this form. Please print or type.** * **Please attach a copy of a voided check, deposit slip, or bank statement.**	
Vendor Name: ________________________________		Please Check One: [ ] New Enrollment [ ] Change	
Vendor Address: ______________________________		Vendor FEIN/SSN: _________	For OSRAP use only. Location Code: _ _
ACH Routing Number:_________	**Circle C for Checking or S for Savings** Check/Savings Ind: **C or S**	Bank Account Number: ________________	
Bank ACCT DESCR: ____			
Bank Name: ________________________________		Bank Address: ________________________________	
Bank Address: ________________________________		Bank Address: ________________________________	
City: ___________________ State: __ ZIP __________		Bank Telephone Number: (___) ___ - ____ Ext ______	

By completing the information listed above, I hereby authorize the State of Louisiana, Division of Administration and their designees (***State***) to initiate ACH credit entries to the financial institution account listed as requested by the individual or organization above (Vendor) for payment of goods and services received. This authorization is to remain in full effect until such time as the ***State*** is notified in writing by the vendor. This notification must include such time and be in such a manner as to afford reasonable time for the ***State*** to act on it. I certify that I am authorized to complete the information listed above in the unshaded areas on behalf of the individual or organization named above and resolve issues related to enrollment. The information presented above is true and correct for the individual or organization named above. I understand that by utilizing the State's EFT payment process, I will no longer receive remittance advices from the State of Louisiana for payments issued. I am instead to contact my financial institution for remittance information and I am utilizing a financial institution which has the capability to receive such information. I am solely responsible for any fees assessed by my financial institution for their services. The ***State*** reserves the right to issue a check for payment when the situation warrants. **I agree to notify the *State* of changes to the information listed on this form immediately. Failure to provide the State with correct information or failure to notify the State of changes to bank and/or account information will result in the Vendor bearing sole liability for lost and/or misdirected payments.**

[ ] Yes. [ ] No **Please check the appropriate box to indicate if the payments you receive are deposited in a U.S. Financial Institution and transferred to an account outside the United States. Yes** means receipts are transferred to an account outside of the U.S. **No** means receipts are not transferred to an account outside of the U.S.

Vendor's Authorized Signature:		Print Name:			
Title and E-mail Address:	/	Date:	__/__/__	Phone #:	(___)___-____ ext ____

FINANCIAL INSTITUTION:

I confirm that the routing and account information listed above is correct and our financial institution has the ability to receive ACH credit files and remittance information electronically.

Financial Institution's Authorized Signature:		Print Name:			
Title and E-mail Address:	/	Date:	__/__/__	Phone #:	(___)___-____ ext ____

Send completed form & void check to DOA-OSRAP EFT Section at P.O. Box 94095, Baton Rouge, LA 70804-9095 or fax to (225) 342-0964

Appendix B— Supporting Documentation and Forms
(8) Site Information Form

LOUISIANA SLRP SITE INFORMATION FORM

	OFFICE USE ONLY-DATE REC'D:
Name and Address of Practice Site:	Name and Address of Employer (if different):
Contact Name and Title: Contact E-mail: Contact Telephone: Contact Fax:	Telephone Number at Practice Site: Fax Number at Practice Site: Employer's telephone: Employer's fax:
Type of Practice: □ Public □ Non-profit □ Both **(provide proof of checked practice type with application)** Type of Facility: □ FQHC □ RHC □ Private □ State □ other _____	Employer's Medicaid ID#: Employer's Medicare ID#
What is the SLRP Clinician's routine work schedule? Include office hours, hospital privileges, call coverage, duties, patient load and an explanation of any special responsibilities for the position.	
How many patients were seen at this location last year?	How many of these patients were uninsured?
How many of these patients were enrolled in Medicaid managed health plans?	How many of these patients were Medicare?
Does this practice site currently have in place a sliding fee scale/indigent care policy for patients below 200% of the Federal poverty level? □ YES □ NO If yes, what percentage of uninsured patients was eligible for reduced fees last year? When was the policy established? _____ When was the policy last updated? _____ Are signs posted to inform patients of this policy? □ Yes □ No **(provide examples of signage/notices in place)**	
Besides posted signs, how does the site ensure that patients are aware of the availability of the sliding fee scale/indigent care policy? Please give details and samples if applicable.	
IMPORTANT NOTE: The applicant will be notified of the decision whether or not to support this request by the end of July. The clinician's contract for SLRP will not begin until October of this year if the clinician is awarded funds. For additional information, contact Beth Butler at 225.342.4702 or beth.butler@la.gov	
Signature:	Date Application Mailed:

Appendix C— Sample Contract

NOTE: This is a SAMPLE contract only. Changes might occur to the document before the next SLRP contracts are mailed out to awardees.

IF AWARDED SLRP FUNDS, READ THE CONTRACT AND ATTACHMENTS CAREFULLY BEFORE SIGNING AND RETURNING TO LA DHH FOR CONTRACT APPROVAL. BY SIGNING THE CONTRACT AND RETURNING IT TO DHH, THE PROFESSIONAL AGREES TO ADHERE TO THE CONTRACT AND ATTACHMENTS AS IT IS WRITTEN AT THAT TIME.

DHH - CF - 1
Revised: 2011-06

AGREEMENT BETWEEN STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS

CFMS:
DHH:
Agency:

Office of Public Health

Bureau of Primary Care and Rural Health

AND

Contractor name, TTL

FOR

□ Personal Services ■ Professional Services □ Consulting Services □ Social Services

1) PROVIDER/CONTRACTOR (LEGAL NAME IF CORPORATION) Contractor name, TTL	**5) FEDERAL EMPLOYER TAX ID# OR SOCIAL SECURITY #** 00 **(MUST BE 11 DIGITS)**
2) STREET ADDRESS	**6) PARISH(ES) SERVED**
CITY **STATE** **ZIP CODE**	**7) LICENSE OR CERTIFICATION #**
3) TELEPHONE NUMBER	**8)** CONTRACTOR STATUS Subrecipient: □ Yes X No Corporation: □ Yes X No For Profit: □ Yes X No Publicly Traded: □ Yes X No
4) MAILING ADDRESS (IF DIFFERENT)	
CITY **STATE** **ZIP CODE**	**8A) CFDA# (FEDERAL GRANT #)** 93.165

9) BRIEF DESCRIPTION OF SERVICES TO BE PROVIDED:

The purpose of the Louisiana State Loan Repayment Program (SLRP) is to recruit primary care practitioners to serve in a federally designated Health Professional Shortage Area (HPSA) in the State of Louisiana. In return for the delivery of primary and preventative health care in an outpatient setting as defined in Attachment 2, the Department of Health and Hospitals (DHH) will provide funds for the repayment of education loans incurred by the health care professional. See Attachment 1 for a detailed description of the contract goals and objectives.

10) EFFECTIVE DATE	**11) TERMINATION DATE**
10/1/14	9/30/17

12) This contract cannot be cancelled by Contractor for convenience or for any cause other than death. Contract services cancelled by Contractor for any reason other than death will be considered default and Contractor shall be subject to the financial consequences outlined in Attachment 3 of the contract. This contract may be cancelled by the Department with or without cause upon 30 day prior written notice.

13) MAXIMUM CONTRACT AMOUNT $.00 TOTALS, FY15- $, FY16-$, FY17- $, FY 18- $

14) TERMS OF PAYMENT

Payment will be made quarterly upon receipt and approval of the quarterly report as invoice of Contractor in accordance with the terms in Attachment 1. Cost reimbursement contract in accordance with the attached budget. The Contractor is obligated to submit final invoices to the Agency within fifteen (15) days after termination of contract.

PAYMENT WILL BE MADE ONLY UPON APPROVAL OF:	**FIRST NAME**	**LAST NAME**
	Avis	Richard-Griffin
	TITLE	**PHONE NUMBER**
	Interim Director	(225) 342-2657

15) SPECIAL OR ADDITIONAL PROVISIONS WHICH ARE INCORPORATED HEREIN, IF ANY (IF NECESSARY, ATTACH SEPARATE SHEET AND REFERENCE):

Attachment 1: Statement of Work
Attachment 2: Services Defined
Attachment 3: Additional Provisions
Attachment 4: Additional Provisions
Attachment 5: HIPAA Addendum
Attachment 6: Quarterly Report Form
Attachment 7: Payment Fee Schedule

Exhibit A: Practitioner's License
Exhibit B: Multi-Year Letter
Exhibit C: Late Letter
Exhibit D: Resume

During the performance of this contract, the Contractor hereby agrees to the following terms and conditions:

1. **Discrimination Clause:** Contractor hereby agrees to abide by the requirements of the following as applicable: Titles VI and VII of the Civil Rights Act of 1964, as amended by the Equal Employment Opportunity Act of 1972; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990; the Rehabilitation Act of 1973; Federal Executive Order 11246 as amended; Title IX of the Education Amendments of 1972; the Age Discrimination Act of 1975; the Fair Housing Act of 1968; and all applicable requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services.
Contractor agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, color, religion, sex, age, national origin, disability, political affiliation, veteran status, or any other non-merit factor. Any act of discrimination committed by Contractor, or failure to comply with these statutory obligations when applicable, shall be grounds for termination of this contract.
2. **Confidentiality:** Contractor shall abide by the laws and regulations concerning confidentially which safeguard information and the patient/client confidentiality. Information obtained shall not be used in any manner except as necessary for the proper discharge of Contractor's obligations. (The Contractor shall establish, subject to review and approval of the Department, confidentiality rules and facility access procedures.)
3. **Auditors:** The State Legislative Auditor, Office of the Governor, Division of Administration, and Department Auditors or those designated by the Department shall have the option of auditing all accounts pertaining to this contract during the contract and for a three year period following final payment. Contractor grants to the State of Louisiana, through the Office of the Legislative Auditor, Department of Health and Hospitals, and Inspector General's Office, Federal Government and/or other such officially designated body the right to inspect and review all books and records pertaining to services rendered under this contract, and further agrees to guidelines for fiscal administration as may be promulgated by the Department. Records will be made available during normal working hours.
Contractor shall comply with federal and state laws and/or DHH Policy requiring an audit of the Contractor's operation as a whole or of specific program activities. Audit reports shall be sent within thirty (30) days after the completion of the audit, but no later than six (6) months after the end of the audit period. If an audit is performed within the contract period, for any period, four (4) copies of the audit report shall be sent to the Department of Health and Hospitals, Attention: **Division of Fiscal Management, P. O. Box 91117, Baton Rouge, LA 70821-3797** and one (1) copy of the audit shall be sent to the **originating DHH Office**.

4. **Record Retention:** Contractor agrees to retain all books, records and other documents relevant to the contract and funds expended thereunder for at least four (4) years after final payment or as prescribed in 45 CFR 74:53 (b) whichever is longer. Contractor shall make available to the Department such records within thirty (30) days of the Department's written request and shall deliver such records to the Department's central office in Baton Rouge, Louisiana, all without expense to the Department. Contractor shall allow the Department to inspect, audit or copy records at the contractor's site, without expense to the Department.
5. **Record Ownership:** All records, reports, documents and other material delivered or transmitted to Contractor by the Department shall remain the property of the Department, and shall be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract. All records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of the Department, and shall, upon request, be returned by Contractor to the Department, at Contractor's expense, at termination or expiration of this contract.
6. **Nonassignability:** Contractor shall not assign any interest in this contract and shall not transfer any interest in the same (whether by assignment or novation), without written consent of the Department thereto, provided, however, that claims for money due or to become due to Contractor from the Department under this contract may be assigned to a bank, trust company or other financial institution without advanced approval. Notice of any such assignment or transfer shall be promptly furnished to the Department and the Division of Administration, Office of State Procurement.
7. **Taxes:** Contractor hereby agrees that the responsibility for payment of taxes from the funds received under this contract shall be Contractor's. The Contractor assumes responsibility for its personnel providing services hereunder and shall make all deductions for withholding taxes, and contributions for unemployment compensation funds.
8. **Insurance:** Contractor shall obtain and maintain during the contract term all necessary insurance including automobile insurance, workers' compensation insurance, and general liability insurance. The required insurances shall protect the Contractor, the Department of Health and Hospitals, and the State of Louisiana from all claims related to Contractor's performance of this contract. Certificates of Insurance shall be filed with the Department for approval. Said policies shall not be canceled, permitted to expire, or be changed without thirty (30) days advance written notice to the Department. Commercial General Liability Insurance shall provide protection during the performance of work covered by the contract from claims or damages for personal injury, including accidental death, as well as claims for property damages, with combined single limits prescribed by the Department.
9. **Travel:** In cases where travel and related expenses are required to be identified separate from the fee for services, such costs shall be in accordance with State Travel Regulations. The contract contains a maximum compensation which shall be inclusive of all charges including fees and travel expenses.
10. **Political Activities:** No funds provided herein shall be used to urge any elector to vote for or against any candidate or proposition on an election ballot nor shall such funds be used to lobby for or against any proposition or matter having the effect of law being considered by the Legislature or any local governing authority. This provision shall not prevent the normal dissemination of factual information relative to a proposition or any election ballot or a proposition or matter having the effect of law being considered by the Legislature or any local governing authority. Contracts with individuals shall be exempt from this provision. this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.
11. **State Employment:** Should Contractor become an employee of the classified or unclassified service of the State of Louisiana during the effective period of the contract, Contractor must notify his/her appointing authority of any existing contract with State of Louisiana and notify the contracting office of any additional state employment. This is applicable only to contracts with individuals.
12. **Ownership of Proprietary Data:** All non-third party software and source code, records, reports, documents and other material delivered or transmitted to Contractor by State shall remain the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract. All non-third party software and source code, records, reports, documents, or other material related to this contract and/or obtained or prepared by Contractor in connection with the performance of the services contracted for herein shall become the property of State, and shall be returned by Contractor to State, at Contractor's expense, at termination or expiration of this contract.
13. **Subcontracting:** Contractor shall not enter into any subcontract for work or services contemplated under this contract without obtaining prior written approval of the Department. Any subcontracts approved by the Department shall be subject to conditions and provisions as the Department may deem necessary; provided, however, that notwithstanding the foregoing, unless otherwise provided in this contract, such prior written approval shall not be required for the purchase by the contractor of supplies and services which are incidental but necessary for the performance of the work required under this contract. No subcontract shall relieve the Contractor of the responsibility for the performance of contractual obligations described herein. 14. **Conflict of Interest:** Contractor warrants that no person and no entity providing services pursuant to this contract on behalf of Contractor or any subcontractor is prohibited from providing such services by the provisions of R.S. 42:1113.

15. **Unauthorized Services:** No claim for services furnished or requested for reimbursement by Contractor, not provided for in this contract, shall be allowed by the Department. In the event the Department determines that certain costs which have been reimbursed to Contractor pursuant to this or previous contracts are not allowable, the Department shall have the right to set off and withhold said amounts from any amount due the Contractor under this contract for costs that are allowable.
16. **Fiscal Funding:** This contract is subject to and conditioned upon the availability and appropriation of Federal and/or State funds; and no liability or obligation for payment will develop between the parties until the contract has been approved by required authorities of the Department; and, if contract exceeds $2,000, the Division of Administration, Office of State Procurement. The continuation of this contract is contingent upon the appropriation of funds from the legislature to fulfill the requirements of the contract. If the Legislature fails to appropriate sufficient monies to provide for the continuation of the contract, or if such appropriation is reduced by the veto of the Governor or by any means provided in the appropriations act to prevent the total appropriation for the year from exceeding revenues for that year, or for any other lawful purpose, and the effect of such reduction is to provide insufficient monies for the continuation of the contract, the contract shall terminate on the date of the beginning of the first fiscal year for which funds are not appropriated. 17. **State and Federal Funding Requirements:** Contractor shall comply with all applicable requirements of state or federal laws or regulations relating to Contractor's receipt of state or federal funds under this contract. If Contractor is a "subrecipient" of federal funds under this contract, as defined in 2 CFR Part 200 (Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards), Contractor shall comply with all applicable requirements of 2 CFR Part 200, including but not limited to the following: ·Contractor must disclose any potential conflict of interest to the Department and the federal awarding agencyas required by 2 CFR §200.112. ·Contractor must disclose to the Department and the federal awarding agency, timely and in writing, all violations of federal criminal laws that may affect the federal award, as required by 2 CFR §200.113. ·Contractor must safeguard protected personally identifiable information and other sensitive information, as required by 2 CFR §200.303. ·Contractor must have and follow written procurement standards and procedures in compliance with federally approved methods of procurement, as required by 2 CFR §§200.317 - 200.326. ·Contractor must comply with the audit requirements set forth in 2 CFR §§200.501 - 200.521, as applicable, including but not limited to: o Electronic submission of data and reports to the Federal Audit Clearinghouse (FAC) (2 CFR §200.512(d)). o Ensuring that reports do not include protected personally identifiable information (2 CFR §200.512(a)(2)). Notwithstanding the provisions of paragraph 3 (Auditors) of these Terms and Conditions, copies of audit reports for audits conducted pursuant to 2 CFR Part 200 shall not be required to be sent to the Department.
18. **Amendments:** Any alteration, variation, modification, or waiver of provisions of this contract shall be valid only when reduced to writing, as an amendment duly signed, and approved by required authorities of the Department; and, if the contract exceeds $2,000, by the Division of Administration, Office of State Procurement. Budget revisions approved by both parties in cost reimbursement contracts do not require an amendment if the revision only involves the realignment of monies between originally approved cost categories.
19. **Non-Infringement:** Contractor will warrant all materials, products and/or services produced hereunder will not infringe upon or violate any patent, copyright, trade secret, or other proprietary right of any third party. In the event of any such claim by any third party against DHH, the Department shall promptly notify Contractor in writing and Contractor shall defend such claim in DHH's name, but at Contractor's expense and shall indemnify and hold harmless DHH against any loss, expense or liability arising out of such claim, whether or not such claim is successful. This provision is not applicable to contracts with physicians, psychiatrists, psychologists or other allied health providers solely for medical services.
20. **Purchased Equipment:** Any equipment purchased under this contract remains the property of the Contractor for the period of this contract and future continuing contracts for the provision of the same services. Contractor must submit vendor invoice with reimbursement request. For the purpose of this contract, equipment is defined as any tangible, durable property having a useful life of at least (1) year and acquisition cost of $1000.00 or more. The contractor has the responsibility to submit to the Contract Monitor an inventory list of DHH equipment items when acquired under the contract and any additions to the listing as they occur. Contractor will submit an updated, complete inventory list on a quarterly basis to the Contract Monitor. Contractor agrees that upon termination of contracted services, the equipment purchased under this contract reverts to the Department. Contractor agrees to deliver any such equipment to the Department within 30 days of termination of services.
21. **Indemnity:** Contractor agrees to protect, indemnify and hold harmless the State of Louisiana, DHH, from all claims for damages, costs, expenses and attorney fees arising in contract or tort from this contract or from any acts or omissions of Contractor's agents, employees, officers or clients, including premises liability and including any claim based on any theory of strict liability. This provision does not apply to actions or omissions for which R.S. 40:1299.39 provides malpractice coverage to the Contractor, nor claims related to treatment and performance of evaluations of persons when such persons cause harm to third parties (R.S. 13:5108.1(E)). Further, it does not apply to premises liability when the services are being performed on premises owned and operated by DHH.

22. **Severability:** Any provision of this contract is severable if that provision is in violation of the laws of the State of Louisiana or the United States, or becomes inoperative due to changes in State and Federal law, or applicable State or Federal regulations.
23. **Entire Agreement:** Contractor agrees that the current contract supersedes all previous contracts, negotiations, and all other communications between the parties with respect to the subject matter of the current contract.
24. **E-Verify**: Contractor acknowledges and agrees to comply with the provision of R.S. 38:2212.10 and federal law pertaining to E-Verify in the performance of services under this contract.
25. **Remedies for Default**: Any claim or controversy arising out of this contract shall be resolved by the provisions of R.S. 39:1672.2-1672.4.
26. **Governing Law**: This contract shall be governed by and interpreted in accordance with the laws of the State of Louisiana, including but not limited to R.S. 39:1551-1736; rules and regulations; executive orders; standard terms and conditions, and specifications listed in the RFP (if applicable); and this Contract.
27. **Contractor's Cooperation**: The Contractor has the duty to fully cooperate with the State and provide any and all requested information, documentation, etc. to the state when requested. This applies even if this Contract is terminated and/or a lawsuit is filed. Specifically, the Contractor shall not limit or impede the State's right to audit or shall not withhold State owned documents.
28. **Continuing Obligation**: Contractor has a continuing obligation to disclose any suspension or debarment by any government entity, including but not limited to the General Services Administration (GSA). Failure to disclose may constitute grounds for suspension and/or termination of the Contract and debarment from future contracts.
29. **Eligibility Status**: Contractor and each tier of Subcontractors, shall certify that it is not excluded, disqualified, disbarred, or suspended from contracting with or receiving federal funds or grants from the Federal Government. Contractor and each tier of Subcontractors shall certify that it is not on the List of Parties Excluded from Federal Procurement and Nonprocurement Programs promulgated in accordance with E.O.s 12549 and 12689, "Debarment and Suspension," as set forth at 24CFR Part 24, and "NonProcurement Debarment and Suspension" set forth at 2CFR Part 2424.
30. **Termination for Cause:** The Department may terminate this Contract for cause based upon the failure of the Contractor to comply with the terms and/or conditions of the Contract; provided that the Department shall give the Contractor written notice specifying the Contractor's failure. If within thirty (30) days after receipt of such notice, the Contractor shall not have either corrected such failure or, in the case of failure which cannot be corrected in thirty (30) days, begun in good faith to correct said failure and thereafter proceeded diligently to complete such correction, then the Department may, at its option, place the Contractor in default and the Contract shall terminate on the date specified in such notice. The Contractor may exercise any rights available to it under Louisiana law to terminate for cause upon the failure of the Department to comply with the terms and conditions of this contract; provided that the Contractor shall give the Department written notice specifying the Department's failure and a reasonable opportunity for the state to cure the defect.
31**. Termination for Convenience:** The Department may terminate this Contract at any time by giving thirty (30) days written notice to the Contractor. The Contractor shall be entitled to payment for deliverables in progress, to the extent work has been performed satisfactorily.
32**. Commissioner's Statements:** Statements, acts and omissions made by or on behalf of the Commissioner of Administration regarding the RFP or RFP process, this Contract, any Contractor and/or any subcontractor of the Contractor shall not be deemed a conflict of interest when the Commissioner is discharging her duties and responsibilities under law, including, but not limited, to the Commissioner of Administration's authority in procurement matters.

SIGNATURES TO FOLLOW ON THE NEXT PAGE

THIS CONTRACT CONTAINS OR HAS ATTACHED HERETO ALL THE TERMS AND CONDITIONS AGREED UPON BY THE CONTRACTING PARTIES. IN WITNESS THEREOF, THIS CONTRACT IS SIGNED ON THE DATE INDICATED BELOW.

CONTRACTOR NAME	**STATE OF LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS**
SIGNATURE **DATE** Contractor name	**SIGNATURE** **DATE** Rebekah E. Gee, MD, MPH
NAME TTL	**NAME** Secretary, DHH
TITLE	**TITLE**
Bureau of Primary Care and Rural Health	**Office of Public Health**
SIGNATURE **DATE** Avis Richard-Griffin	**SIGNATURE** **DATE** Beth Scalco
NAME Director	**NAME** Assistant Secretary
TITLE	**TITLE**

Attachment 1
LAGov#:
Name

Rev. 09/2013

HIPAA Business Associate Addendum

This HIPAA Business Associate Addendum is hereby made a part of this contract in its entirety as **Attachment 1** to the contract.

1. The Louisiana Department of Health and Hospitals ("DHH") is a Covered Entity, as that term is defined herein, because it functions as a health plan and as a health care provider that transmits health information in electronic form.
2. Contractor is a Business Associate of DHH, as that term is defined herein, because contractor either: (a) creates, receives, maintains, or transmits PHI for or on behalf of DHH; or (b) provides legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services for DHH involving the disclosure of PHI.
3. Definitions: As used in this addendum –
   A. The term "HIPAA Rules" refers to the federal regulations known as the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules, found at 45 C.F.R. Parts 160 and 164, which were originally promulgated by the U. S. Department of Health and Human Services (DHHS) pursuant to the Health Insurance Portability and Accountability Act ("HIPAA") of 1996 and were subsequently amended pursuant to the Health Information Technology for Economic and Clinical Health ("HITECH") Act of the American Recovery and Reinvestment Act of 2009.
   B. The terms "Business Associate", "Covered Entity", "disclosure", "electronic protected health information" ("electronic PHI"), "health care provider", "health information", "health plan", "protected health information" ("PHI"), "subcontractor", and "use" have the same meaning as set forth in 45 C.F.R. § 160.103.
   C. The term "security incident" has the same meaning as set forth in 45 C.F.R. § 164.304.
   D. The terms "breach" and "unsecured protected health information" ("unsecured PHI") have the same meaning as set forth in 45 C.F.R. § 164.402.
4. Contractor and its agents, employees and subcontractors shall comply with all applicable requirements of the HIPAA Rules and shall maintain the confidentiality of all PHI obtained by them pursuant to this contract and addendum as required by the HIPAA Rules and by this contract and addendum.
5. Contractor shall use or disclose PHI solely: (a) for meeting its obligations under the contract; or (b) as required by law, rule or regulation (including the HIPAA Rules) or as otherwise required or permitted by this contract and addendum.
6. Contractor shall implement and utilize all appropriate safeguards to prevent any use or disclosure of PHI not required or permitted by this contract and addendum, including administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DHH.
7. In accordance with 45 C.F.R. § 164.502(e)(1)(ii) and (if applicable) § 164.308(b)(2), contractor shall ensure that any agents, employees, subcontractors or others that create, receive, maintain, or transmit PHI on behalf of contractor agree to the same restrictions, conditions and requirements that apply to contractor with respect to such information, and it shall ensure that they implement reasonable and appropriate safeguards to protect such information. Contractor shall take all reasonable steps to ensure that its agents', employees' or subcontractors' actions or omissions do not cause contractor to violate this contract and addendum.
8. Contractor shall, within three (3) days of becoming aware of any use or disclosure of PHI, other than as permitted by this contract and addendum, report such disclosure in writing to the person(s) named in section 14 (Terms of Payment), page 1 of the CF-1. Disclosures which must be reported by contractor include, but are not limited to, any security incident, any breach of unsecured PHI, and any "breach of the security system" as defined in the Louisiana Database Security Breach Notification Law, La.R.S. 51:3071 *et seq*. At the option of DHH, any harm or damage resulting from any use or disclosure which violates this contract and addendum shall be mitigated, to the extent practicable, either: (a) by contractor at its own expense; or (b) by DHH, in which case contractor shall reimburse DHH for all expenses that DHH is required to incur in undertaking such mitigation activities.
9. To the extent that contractor is to carry out one or more of DHH's obligations under 45 C.F.R. Part 164, Subpart E, contractor shall comply with the requirements of Subpart E that apply to DHH in the performance of such obligation(s).
10. Contractor shall make available such information in its possession which is required for DHH to provide an accounting of disclosures in accordance with 45 CFR § 164.528. In the event that a request for accounting is made directly to contractor, contractor shall forward such request to DHH within two (2) days of such receipt. Contractor shall implement an appropriate record keeping process to enable it to comply with the requirements of this provision. Contractor shall maintain data on all disclosures of PHI for which accounting is required by 45 CFR § 164.528 for at least six (6) years after the date of the last such disclosure.
11. Contractor shall make PHI available to DHH upon request in accordance with 45 CFR § 164.524.
12. Contractor shall make PHI available to DHH upon request for amendment and shall incorporate any amendments to PHI in accordance with 45 CFR § 164.526.
13. Contractor shall make its internal practices, books, and records relating to the use and disclosure of PHI received from or created or received by contractor on behalf of DHH available to the Secretary of the U. S. DHHS for purposes of determining DHH's compliance with the HIPAA Rules.
14. Contractor shall indemnify and hold DHH harmless from and against any and all liabilities, claims for damages, costs, expenses and attorneys' fees resulting from any violation of this addendum by contractor or by its agents, employees or subcontractors, without regard to any limitation or exclusion of damages provision otherwise set forth in the contract.
15. The parties agree that the legal relationship between DHH and contractor is strictly an independent contractor relationship. Nothing in this contract and addendum shall be deemed to create a joint venture, agency, partnership, or employer-employee relationship between DHH and contractor.
16. Notwithstanding any other provision of the contract, DHH shall have the right to terminate the contract immediately if DHH determines that contractor has violated any provision of the HIPAA Rules or any material term of this addendum.
17. At the termination of the contract, or upon request of DHH, whichever occurs first, contractor shall return or destroy (at the option of DHH) all PHI received or created by contractor that contractor still maintains in any form and retain no copies of such information; or if such return or destruction is not feasible, contractor shall extend the confidentiality protections of the contract to the information and limit further uses and disclosure to those purposes that make the return or destruction of the information infeasible.

ATTACHMENT 2—Statement of Work

The additional terms of this agreement are set forth below.

Section A: Goal of Agreement:

To provide primary health care services within the following officially designated HPSA(s) and public and non-profit private facility: Facility Name, facility address; HPSA #

Section B: Deliverables: Obligations of the health care professional

The contractor agrees:

To provide primary health care encounters/services as defined in Attachment 2.

To provide the Department with a copy of the loan statement which applies to this contract stating the current loan balance to be submitted to the State Loan Repayment Program Coordinator by April 15th and October 15th of each year. All contracted funds must be paid in full and verification provided within 30 days of receipt of the last payment.

To provide the Department with a copy of an employment contract with a facility located in a HPSA at application and if employment changes. All employment changes must be approved by DHH Program Monitor.

To attest that the educational loans being repaid by this contract were incurred for the contractor's health professional education, including reasonable living expenses during the time that medical education was received.

To attest that the contractor's educational loans are not in default.

To attest that **no** other obligation (federal, state or local repayment program) is being repaid (service or monies) during this contract period.

To charge for professional services at the usual and customary rate prevailing in the area in which such services are provided, except that if a person is unable to pay such charge, such person shall be charged at a reduced rate or not charged any fee.

To provide health services and not discriminate against any person on the basis of such person's ability to pay for such services or because payment for health services provided to such person will be made under the insurance program established under part A or B of Title XVIII of the Social Security Act or under a State plan for medical assistance approved under Title XIX or Title XXI of such Act.

To attest that the contractor will not relocate to another HPSA employment site without a written request and prior approval from the Department's State Loan Repayment Program Monitor. After approval, a letter of employment is required to be submitted to the Department's SLRP Monitor stating the effective date of employment, hours to be worked, that the facility accepts Medicaid, Medicare, and sliding fee scale patients, as well as, patients that cannot pay, and that the contractor is a provider for all Louisiana Medicaid programs.

To notify the Department in writing of any changes in the contractor's situation (i.e., name change, mailing address, phone number, loan default status, licensure status, etc.).

ATTACHMENT 2—Statement of Work (continued)

Section C: Performance Measures

The contractor will:

Provide the Department with a statement guaranteeing that the employment site accepts Medicaid, Medicare and sliding fee scale patients and is an enrolled provider for all Louisiana Medicaid programs. ***The facility must post a notice in a conspicuous place in the waiting room of the practice so that all people registering for service can see the notice which states that the facility has a sliding fee scale and that all patients will be seen regardless of their ability to pay.***

Provide the Department with **A SIGNED QUARTERLY SERVICE REPORT BY THE 15TH** of the following month which totals the number of encounters rendered. ***The report shall detail the number of patient encounters for each of the following: Medicare, Medicaid, sliding scale, uninsured/self pay; or special populations for which extra funding was awarded, i.e., AIDS/HIV, Homeless, Migrant***. Arrangements for the tracking of this information should be made with the employment site.

Accept an assignment under section 1842(b)(3)(ii) of such Act for all services for which payment may be made under part B of Title XVIII of the Social Security Act.

Enter into an appropriate agreement with the State agency which administers the State plan for medical assistance under Title XIX or Title XXI of the Social Security Act.

Section D: Monitoring of Agreement

The agreement will be monitored via the following methods to which the contractor agrees:

That the Department representative may make announced or unannounced on-site visits for the purpose of program monitoring at any time during the length of the contract term.

That the Department has the right to verify service reports including written and/or verbal contacts with the professional, patient(s), hospital(s), medical society(s) and employer(s) at any time.

ATTACHMENT 3—Payment Fee Schedule

Based upon receipt of the completed quarterly service reports payments will be made as follows:

State Fiscal Year 2016

October 1, 2015-December 31, 2015 = $___
January 1, 2016-March 31, 2016 = $___
April 1, 2016-June 30, 2016 = $___

Total: $___

State Fiscal Year 2017

July 1, 2016-September 30, 2016 = $__
October 1, 2016-December 31, 2016 = $___
January 1, 2017-March 31, 2017 = $___
April 1, 2017-June 30, 2017 = $___

Total: $__

State Fiscal Year 2018

July 1, 2017-September 30, 2017 = $___
October 1, 2017-December 31, 2017 = $___
January 1, 2018-March 31, 2018 = $___
April 1, 2018-June 30, 2018 = $___

Total: $___

State Fiscal Year 2019

July 1, 2018-September 30, 2018 = $____

NOTE: Quarters for payments are—

Quarter 1: January through March—payment in April
Quarter 2: April through June—payment in July
Quarter 3: July through September—payment in October
Quarter 4: October through December—payment in January

Payment Totals for SFY16 = $.00
Payment Totals for SFY17 = $.00
Payment Totals for SFY18 = $.00
Payment Totals for SFY19 = $.00
Contract Total: = $.00

ATTACHMENT 4—Services Defined

Physicians/Dentists: Primary health care services rendered by physicians/dentists must be full-time and are defined as a minimum forty (40) hour work week to be performed in no less than four (4) days per week with no more than twelve (12) hours of work to be performed in a 24 hour period. Time spent in an "on-call" status will not count toward the 40 hour week. Physicians/dentists must work at least 32 of the minimum 40 hours per week providing clinical services in an outpatient/ambulatory setting except obstetricians/gynecologists must work at least 21 of the 40 hours providing clinical services in this type setting. Contractors are allowed up to seven (7) weeks a year away from the practice site for vacations, holidays, continuing professional education, illness or any other reason; professionals with absences greater than seven (7) weeks in a service year must extend their service commitment date. A primary health care encounter is face-to-face contact between the contracting physician/dentist and a patient for the purpose of preventive care, diagnosis and/or treatment. Contacts with more than one health professional and/or multiple contacts with the same contracting physician/dentist that takes place on the same day constitutes a single encounter unless the patient, subsequent to the first visit, suffers illness or injury requiring additional diagnosis or treatment.

Mid-levels: Health care services rendered by primary care nurse practitioners (NPs); certified nurse-midwives (NMs); primary care physician assistants (PAs); registered clinical dental hygienists (DHs); licensed clinical or counseling psychologists (LCPs); licensed clinical social workers (LCSWs); psychiatric nurse specialists (PNSs); mental health counselors (MHCs); licensed professional counselors (LPCs); and marriage and family therapists (MFTs) must be full-time in an outpatient setting and are defined as a minimum forty (40) hour work week to be performed in no less than four (4) days per week with no more than twelve (12) hours of work to be performed in a 24 hour period. Mid-levels must work at least 32 of the minimum 40 hours per week providing clinical services in an outpatient/ambulatory setting except nurse midwives who must work at least 21 of the 40 hours providing clinical services in this type setting. Contractors are allowed up to seven (7) weeks a year away from the practice site for vacations, holidays, continuing professional education, illness or any other reason; professionals with absences greater than seven (7) weeks in a service year must extend their service commitment date.

ATTACHMENT 5—Default Provisions

This contract cannot be cancelled by Contractor for convenience or for any cause other than death. Contract services cancelled by Contractor for any reason other than death will be considered default and Contractor shall be subject to the financial consequences outlined below. This contract may be cancelled by the Department with or without cause upon 30 day prior written notice.

DEFAULT: SLRP Contractors who fail to begin or complete his/her SLRP service obligation or otherwise breach the terms and conditions of the obligation are in default of his/her contract and are subject to the financial consequences outlined below in this Attachment. Examples of default are:

- Failure to begin or complete service term
- Failure to accept Medicaid, Medicare and LaCHIP assignment or implement a sliding fee schedule for low-income, uninsured people
- Failure to provide documentation of qualifying loans upon request/demand
- Failure to apply SLRP funds to either (a) the repayment of qualifying educational loan balances or (b) the state income tax owed on the SLRP payments disbursed through this contract, up to the 6% of the contract amount
- Failure to maintain eligibility as a Medicaid or Medicare provider

If a health professional is unable to complete the service obligation at the initial placement, assistance will be provided to find another eligible placement. If a contractor chooses not to find and accept a placement transfer/reassignment, then DHH must place the contractor in default of the SLRP contract.

If the contractor breaches a SLRP obligation, the contractor will be subject to pay an amount equal to the sum of the following:

a. The total amount paid by the SLRP to, or on behalf of, the participant for loan repayment for any period of obligated service not served;

b. An amount equal to the number of months of obligated service not completed multiplied by $7,500; AND

c. Interest on the above amounts at the maximum legal prevailing rate, as determined by the treasurer of the United States, from the date of breach.

NOTE: The minimum amount that Louisiana DHH is entitled to recover will not be less than $31,000.

Example: A physician has a contract for $90,000.00 for a 3-year term of service and voluntarily quits her job after 18 months to move to another state. Her monthly payment amount is 2,500.00. Her monthly payment is made following the service month. The maximum legal interest rate at the time is 18%. The following method would be used to calculate the amount of the default penalty owed by the physician to DHH at the time of default:

THE DEFAULT PAYMENT OWED TO DHH = Section a + Section b + Section c

Section a = 0 (payments are made after the term of service)

Section b = (36-18)*$7,500.00
= 18 * $7,500.00
= $135,000.00

Section c = (0*18%) + ($135,000.00*18%)
= 0 + $24,300.00
= $24,300.00

Total owed to DHH = 0 + $135,000.00 + $24,300.00 = $159,300

ATTACHMENT 6—Cancellation Provisions

Contractors agree to adhere to all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services.

Cancellation Policy: ***The only permissible basis for a SLRP participant to cancel a SLRP contract is the death of the SLRP participant. A SLRP contract cannot be canceled in order to allow an individual to participate in the NHSC LRP or for any other reason except the SLRP participant's death.***

Waivers on SLRP contract obligations may be granted by the Secretary of the Department of Health and Hospitals in the event of certain circumstances. Waiver is a permanent status. In order to qualify for a waiver of the SLRP obligation, a participant must document a medical condition or a personal situation that makes compliance with the obligation permanently "impossible" or an "extreme hardship" such that enforcement would be against equity and good conscience. An example would be an illness so debilitating that the participant can no longer practice his/her profession.

Suspension of the participant's SLRP obligation may be granted for up to 1 year. In order to qualify for a suspension, the participant must document a medical condition or personal situation that makes compliance with the obligation temporarily "impossible" or an "extreme hardship" such that enforcement would be against equity and good conscience. Examples would be the terminal illness of an immediate family member for whom the participant is caretaker, or maternity leave.

Should the contractor default on the contract, payment will be required in accordance with the formula outlined in Attachment 3 by the end of the current state fiscal year.

See Attachment 1 for additional contract specifications.

Regardless of any other provision contained in this agreement between the Department and the contractor, the Department does not hereby become individually obligated to the Lender (s) *of the qualified educational loans* by this agreement for any obligation or loan which the contractor owes to said Lender.

Any additional terms and/or conditions, or special provisions, mandated by either the State of Louisiana or by the Federal Authority of the United States, shall be added onto the existing contractual agreements as Attachment Z.

Attachment 7—Quarterly Report
Monitoring Form

Quarterly Service Report for LA State Loan Repayment Program (SLRP)

Please mail or fax to: **Beth Butler**
Department of Health and Hospitals
628 N. 4th St.
Baton Rouge, LA 70802
Phone: (225) 342-4702
Fax: (225) 342-5839

Contractor: contractor name, title		
Home Address: Contractor address	**Practice Name/Address:** Facility name Facility address	**Social Security Number** SSN
Home Telephone Number: CONTRACTOR PHONE	**Practice Telephone Number:**	**Practice Fax Number:**

*Please update above information for any changes.

FOR SERVICES RENDERED IN: ____/____ TO ____/____ -- QTR 1/2/3/4 **Month/Year Month/Year** ***(circle one)***	
Number of **outpatient(clinical) hours** worked:	**Total** number of hours worked:
Number of patient encounters this quarter:	Number of patients this quarter:
Patient Profile Statistics: Complete each item. Please indicate ACTUAL or ESTIMATED.	
Number of Medicare patients:	Number of patients using Sliding Fee Scale:
Number of Medicaid patients:	Number of patients who are uninsured:
Fill out information below if SLRP funding was based on treating patients of the types listed.	
Number of patients with AIDS/HIV:	Number of perinatal patients:
Number of migrant patients:	Number of homeless patients:
Comments:	

The following signatures certify that services were rendered as recorded above by the **SLRP** contractor during the report quarter.

_____ _____
SLRP Professional's Employer's (or Representative's) Signature Date

_____ _____
SLRP Professional's Signature Date

This report with the approval signature from the program director serves as an invoice to process quarterly payments under SLRP Professional Services/Social Services in accordance with the Terms of Payment in the above contracts.

_____ _____

Louisiana DHH's SLRP Program Director Date

NOTE: Quarters for payments are—

Quarter 1: January through March—Report due by April 15
Quarter 2: April through June—Report due by July 15
Quarter 3: July through September—Report due by October 15
Quarter 4: October through December—Report due by January 15

If reports are not submitted by the 15th of the month they are due, then payment is not guaranteed

Section c = (0*18%) + ($135,000.00*18%)
= 0 + $24,300.00
= $24,300.00

Total owed to DHH = 0 + $135,000.00 + $24,300.00
= $159,300

Appendix D— Sample Sliding Fee Scale

Examples of Discounted/Sliding Fee Schedules for the Lower 48 Contiguous States

Annual Income Thresholds by Sliding Fee Discount Pay Class and Percent Poverty						
Poverty Level*	**100%**	**125%**	**150%**	**175%**	**200%**	**>200%**
Family Size	Minimum Fee	20% pay	40% pay	60% pay	80% pay	100% pay
1	$11,490	$14,363	$17,235	$20,108	$22,980	$22,981
2	$15,510	$19,388	$23,265	$27,143	$31,020	$31,021
3	$19,530	$24,413	$29,295	$34,178	$39,060	$39,061
4	$23,550	$29,438	$35,325	$41,213	$47,100	$47,101
5	$27,570	$34,463	$41,355	$48,248	$55,140	$55,141
6	$31,590	$39,488	$47,385	$55,283	$63,180	$63,181
7	$35,610	$44,513	$53,415	$62,318	$71,220	$71,221
8	$39,630	$498,538	$59,445	$69,353	$79,260	$79,261
For each additional person, add	$4,020	$5,025	$6,030	$7,035	$8,040	$8,040

* Based on 2013 HHS Poverty Guidelines (http://aspe.hhs.gov/poverty/13poverty.cfm)

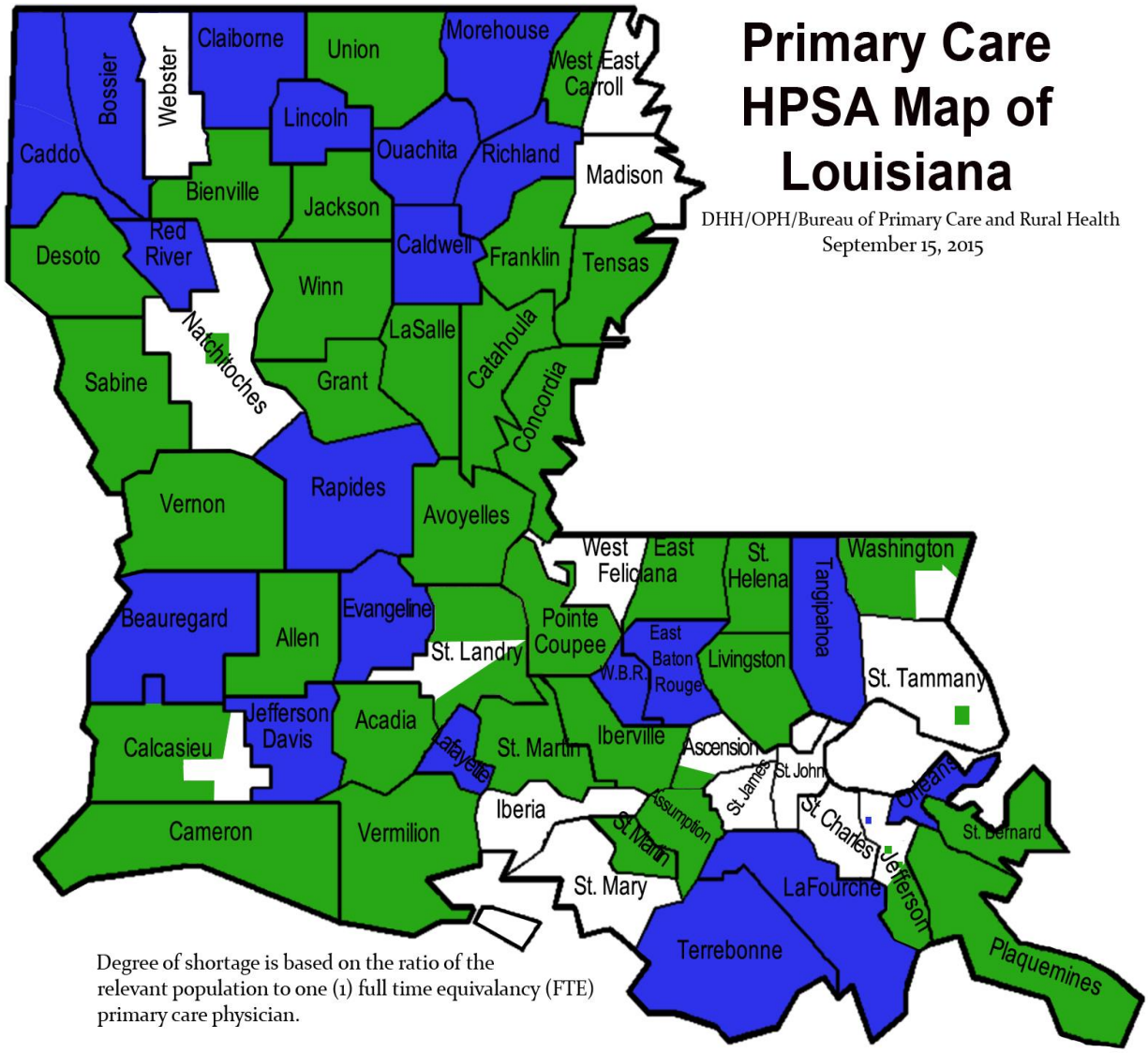
Maximum Annual Income Amounts for each Sliding Fee Percentage Category (except for 0% discount)												
Poverty Level*	**100%**	**110%**	**120%**	**130%**	**140%**	**150%**	**160%**	**170%**	**180%**	**190%**	**200%**	**>200%**
Family Size	DISCOUNT											
	100%	100%	90%	80%	70%	60%	50%	40%	30%	20%	10%	0%
1	$11,490	$12,639	$13,788	$14,937	$16,086	$17,235	$18,384	$19,533	$20,682	$21,831	$22,980	$22,981
2	$15,510	$17,061	$18,612	$20,163	$21,714	$23,265	$24,816	$26,367	$27,918	$29,469	$31,020	$31,021
3	$19,530	$21,483	$23,436	$25,389	$27,342	$29,295	$31,248	$33,201	$35,154	$37,107	$39,060	$39,061
4	$23,550	$25,905	$28,260	$30,615	$32,970	$35,325	$37,680	$40,035	$42,390	$44,745	$47,100	$47,101
5	$27,570	$30,327	$33,084	$35,841	$38,598	$41,355	$44,112	$46,869	$49,626	$52,383	$55,140	$55,141
6	$31,590	$34,749	$37,908	$41,067	$44,226	$47,385	$50,544	$53,703	$56,862	$60,021	$63,180	$63,181
7	$35,610	$39,171	$42,732	$46,293	$49,854	$53,415	$56,976	$60,537	$64,098	$67,659	$71,120	$71,221
8	$39,630	$45,593	$47,556	$51,519	$55,482	$59,445	$63,408	$67,371	$71,334	$75,297	$79,260	$79,261
For each additional person, add	$4,020	$4,422	$4,824	$5226	$5,628	$6,030	$6,432	$6,834	$7,236	$7,638	$8,040	$8,040

* Based on 2013 HHS Poverty Guidelines (http://aspe.hhs.gov/poverty/13poverty.cfm)

Appendix E—Maps

(1) Health Professional Shortage Area (HPSA)

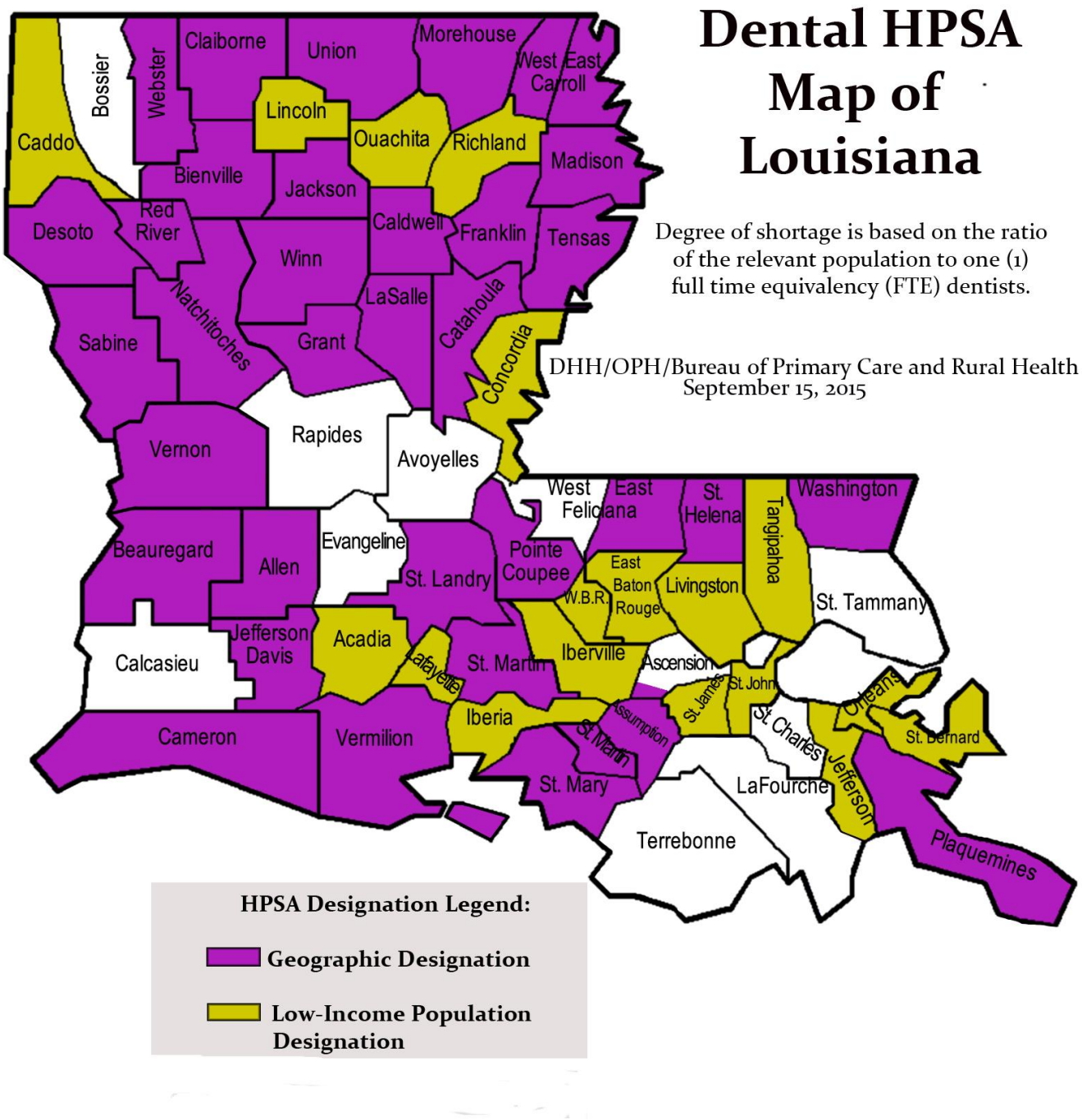
(a) Primary Care Designations



Appendix E—Maps

(1) Health Professional Shortage Area (HPSA)

(b) Dental Health Designations



Appendix E—Maps

(1) Health Professional Shortage Area (HPSA)

(c) Mental Health Designations