



TEXAS HIGHER EDUCATION COORDINATING BOARD
Application for Enrollment in the
Physician Education Loan Repayment Program

ELIGIBILITY REQUIREMENTS - Physicians must:

- Be a U.S. citizen or a Legal Permanent Resident and hold a full physician license from the Texas Medical Board, with no restrictions
- Be eligible to take the exam for board certification from specialty boards established in THECB administrative rules, if the physician has not earned and maintained board certification
- Agree to provide four consecutive years of service in a (1) federally designated Health Professional Shortage Area (HPSA), (2) secure correctional facility operated by or under contract with the Texas Juvenile Justice Department*, or (3) secure correctional facility operated by or under contract with the Texas Department of Criminal Justice*
- Provide direct patient care to Medicaid enrollees and CHIP enrollees, if the practice includes children
- Not be currently fulfilling another obligation to provide medical services as part of a scholarship agreement, a student loan agreement, or another student loan repayment program

**Limited to 10 participants each year*

APPROVED PRIMARY CARE SPECIALTIES

- | | |
|-----------------------------------|-----------------------|
| • Family Medicine/Family Practice | • Medicine-Pediatrics |
| • General Practice | • General Pediatrics |
| • Obstetrics/Gynecology | • Psychiatry |
| • General Internal Medicine | • Geriatrics |

SERVICE PERIOD

The service period is a period of twelve consecutive months, generally beginning on the date the application is received or the date qualifying employment begins, whichever is later.

REPAYMENT AWARDS

Annual loan repayments are disbursed directly to the lender/servicer following completion of each service period. Physicians whose student loan indebtedness is at least \$160,000 may qualify for the amounts shown below, based on full-time service. For physicians owing less than \$160,000 on their student loans, the annual loan repayment amounts based on full-time service will be the amounts required to repay the indebtedness over a period of four years, with annual increases that are proportional to the annual increases for physicians owing at least \$160,000 on their student loans, as follows:

- \$25,000 for the first service period or 16% of the amount owed, if the total is less than \$160,000
- \$35,000 for the second service period or 22% of the amount owed, if the total is less than \$160,000
- \$45,000 for the third service period or 28% of the amount owed, if the total is less than \$160,000
- \$55,000 for the fourth service period or 34% of the amount owed, if the total is less than \$160,000

The following conditions render loans **INELIGIBLE** for repayment through the PELRP: (1) loans made during residency or to cover costs during residency, (2) loans in a default status, (3) loans having an existing service obligation, and (4) loans that are subject to repayment through another student loan repayment or forgiveness program.

Applications must be postmarked by **May 31, 2015**, and may be mailed to the address below or faxed. Please call (512) 427-6357 or (512) 427-6477 for information on e-mailing applications using secure e-mail.

Texas Higher Education Coordinating Board
PO Box 12788
Austin, Texas 78711-2788

For questions or comments, e-mail: loanrepaymentprograms@theeb.state.tx.us
To select link to program web page: www.theeb.state.tx.us/lrp
FAX (512) 427-6555



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Part 1 - Applicant and Loan Information

*Social Security #: _____ - _____ - _____ Date of Birth: _____ / _____ / _____

Name: _____ Any Prior Name(s): _____

Home Address: _____ Home Phone #: (_____) _____ - _____

_____ Other Phone #: (_____) _____ - _____

_____ E-mail: _____

City _____ State _____ Zip Code _____

Degree: ☐ MD ☐ DO TX Medical License No: _____ NPI No.: _____ TPI No.: _____

Provide the following information for all student loans that you obtained to pay for undergraduate, graduate, or medical education. Loans obtained during residency training or for post-medical school costs are ineligible. Please list your loans in the order in which you would like for them to be repaid.

	Lender/Service	Loan Type/Program	Estimated Loan Balance
Priority 1	_____	_____	_____
Priority 2	_____	_____	_____
Priority 3	_____	_____	_____
Priority 4	_____	_____	_____
Priority 5	_____	_____	_____

Did the promissory note or governing terms of the loans listed above require that the loan proceeds be used for expenses incurred by you to pay for the cost of attendance for your undergraduate, graduate, or medical education?
☐ Yes ☐ No If no, state the priority number(s) of the loan(s) that did not: _____

Were any of the loans listed above obtained during residency training or to cover post-medical school expenses?
☐ Yes ☐ No If yes, state the priority number(s) of the loan(s) that were: _____

Are any of the loans listed above in a default status?
☐ Yes ☐ No If yes, state the priority number(s) of the loan(s) in default: _____

Have any of the loans listed above been consolidated with non-educational loans or included in a spousal consolidation?
☐ Yes ☐ No If yes, state the priority number(s) of the consolidated loans: _____

Do any of the loans listed above entail a service obligation?
☐ Yes ☐ No If yes, state the priority number(s) of the loans that do: _____

Are any of the loans listed above subject to repayment through another student loan repayment or loan forgiveness program?
☐ Yes ☐ No If yes, state the priority number(s) of the loans that are: _____

Are you participating in any other loan repayment or loan forgiveness program?
☐ Yes ☐ No

Are you a U.S. citizen or Legal Permanent Resident?
☐ Yes ☐ No

*Please refer to the Privacy Act Notice on page 4 of this application. The Coordinating Board must enter the SSN to verify federal loan information using the National Student Loan Data System. For information on non-federal student loans, the last four digits of the SSN or the account number is needed.



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Part 2 – Employment and Facility Information

Name of Applicant _____

Any Prior Name(s) _____

Name of Employer _____

Date of Birth _____

Facility Name _____

Facility County _____

Facility Street Address _____

Facility Phone Number _____

City _____ State _____ Zip Code _____

Beginning date of service _____ Position Title _____

I am ☐ Board Certified in the practice specialty shown below

☐ Eligible to take the exam for board certification

☐ Family Practice/Family Medicine ☐ General Practice ☐ OB/GYN ☐ General Internal Medicine
☐ General Pediatrics ☐ Medicine-Pediatrics ☐ Psychiatry ☐ Geriatrics ☐ Other (state) _____

☐ I am practicing the specialty for which I am certified/on track for certification; if not, indicate the specialty being practiced: _____

Facility type: ☐ Clinic ☐ Hospital ☐ Community Health Center ☐ Rural Health Clinic
☐ Texas Juvenile Justice Department (TJJD) ☐ Texas Department of Criminal Justice

Full-time clinical practice is defined as a minimum of 32.5 hours of direct patient care per week. Prorated repayment awards may be disbursed for physicians providing at least 20 hours of direct patient care per week. **Do Not Include Time in Preceptorship or On-Call Time.**

Total hours per week anticipated at this facility during the 12-month service period: _____

Anticipated hours per week providing direct patient care at this facility during the 12-month service period: _____

Indicate the number of sites where service is going to be provided. **(A separate form is required for each location):** _____

☐ I understand that the Physician Education Loan Repayment Program disbursements are made annually following verification of completion of twelve consecutive months of service and are contingent upon the availability of funds.

☐ I agree to provide at least four consecutive years of service in a federally designated Health Professional Shortage Area or secure correctional facility operated by or under contract with the Texas Department of Juvenile Justice or the Texas Department of Criminal Justice. I understand that I will be released from this agreement for any year of service for which loan repayment funds are not available.

☐ I understand that the law requires participating physicians to serve patients enrolled in Medicaid and CHIP (for practices serving children). Additionally, the THECB is required to solicit and collect the number of patients enrolled in Medicaid who are treated by physicians receiving loan repayment. I will be asked to provide the estimated percentage of patients who are uninsured and who are enrolled in Medicaid or the Children's Health Insurance Program.

By my signature below, I certify that the information provided in all parts of this application is true and correct.

Signature: _____

Date Signed: _____ / _____ / _____

Warning: A person submitting misleading or fraudulent information to the Texas Higher Education Coordinating Board in an attempt to obtain financial aid is subject to criminal prosecution.



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Authorization to Release Student Loan Information

Participant Authorization

Name: _____ **Date of Birth:** ____ / ____ / ____

Last Four Digits of Social Security #: _____ **Any Prior Name(s):** _____

Home Address: _____ **Home Phone #:** (_____) _____

_____ **Other Phone #:** (_____) _____

_____ **E-mail:** _____

City _____ **State** _____ **Zip Code** _____

I have applied for participation in the Physician Education Loan Repayment Program and authorize my student loan lender and/or servicer to release information regarding my loan(s) to the Texas Higher Education Coordinating Board.

Signature: _____ **Date Signed:** ____ / ____ / ____

Privacy Act Notice

Certain information required on the application is made confidential by the Privacy Act of 1974 (5 USC 552a). The requested information is necessary for participation in the Physician Education Loan Repayment Program, to verify your identity and to determine your eligibility for the program and for any benefits from it. The Privacy Act provides that an agency may continue to require disclosure of an applicant's Social Security Number (SSN) as a condition for the granting of a right, benefit, or privilege if the agency required this disclosure prior to January 1975. The Texas Higher Education Coordination Board has, for years prior to 1975, required the disclosure of the SSN of all applicants for the programs that it administers. The SSN may be used to verify your identity and as an account number (identifier) throughout your participation in the program, in order to make certain that THECB records necessary data accurately. As an identifier, the SSN will be used to determine program eligibility.

The following notices are provided in accordance with Texas Government Code, Section 559.003(a):

1. With few exceptions, you are entitled on request to be informed what information THECB collects about you, and to receive and review the information.
2. Under Section 559.004 of the Government Code, you are entitled to have THECB correct information about you that is incorrect. You may do so by writing to Physician Education Loan Repayment Program, Texas Higher Education Coordinating Board, P.O. Box 12788, Austin, Texas 78711.
3. The information that the Texas Higher Education Coordinating Board collects will be retained and maintained as required by Texas record retention laws (Texas Government Code, Section 441.180 et seq.) and rules. Different types of information are kept for different periods of time.

Warning: A person submitting misleading or fraudulent information to the Texas Higher Education Coordinating Board in an attempt to obtain financial aid is subject to criminal prosecution.