TEXAS HIGHER EDUCATION COORDINATING BOARD

Physician Education Loan Repayment Program

End of Service Period Instructions

To request Physician Education Loan Repayment Program student loan repayment, please ensure that the following three completed forms are received by the Texas Higher Education Coordinating Board as soon as possible:

- Participant Application for Payment
- Service Verification
  1. HB 2550, passed by the 83rd Texas Legislature, Regular Session, requires that the Coordinating Board "solicit and collect information regarding the number of patients enrolled in Medicaid and CHIP who are treated by each physician receiving loan repayment assistance" through this program.
  2. The bottom half of the service verification form **must** be completed by the practice or facility administrator who is authorized to certify employment records. The physician should not enter information in this section of the form.
- Authorization to Release Student Loan Information

Mail or fax completed forms to:

Texas Higher Education Coordinating Board
PO Box 12788
Austin, Texas 78711-2788
FAX #: (512) 427-6555

Please contact Stacy Johnson at (512) 427-6357 or Alicia Mata-Radtke at (512) 427-6477 for instructions if you wish to submit your application by secure e-mail.

If you have any questions regarding completion of the forms, please contact the THECB by email at www.thecb.state.tx.us/lrp "Contact Us" link or call 512-427-6340 or 1-800-242-3062 (if calling from outside the Austin area).

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 eligibility 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.

TEXAS HIGHER EDUCATION COORDINATING BOARD

Physician Education Loan Repayment Program

Participant Application for Payment

To be completed by the physician

Name:_____ Any Prior Name(s):_____

Social Security #:_____ Date of Birth:_____

Home Address:_____ Home Phone #:_____

_____ Other Phone #:_____

_____ E-mail:_____

City State Zip Code

Degree: ☐ MD ☐ DO

Texas Medical License No.:_____ TPI No.: _____ NPI No.:_____

Provide the following information for all eligible educational loans received during your undergraduate, graduate, or medical education. Loans received during residency training are ***not*** eligible.

Name of Lender or Servicer	Account Number	Estimated Balance	% of Award to be Applied to the Loan
1._____	_____	_____	_____%
2._____	_____	_____	_____%
3._____	_____	_____	_____%
4._____	_____	_____	_____%
5._____	_____	_____	_____% (Must total 100%)

Have any of the loans listed above been consolidated with a spouse's loans or non-educational loans?

☐ Yes ☐ No If yes, indicate the number(s) corresponding to the consolidated loan(s):_____

I certify the following:

1. The loans listed above: (a) are evidenced by a promissory note to pay for the cost of attendance for undergraduate, graduate, or medical education; (b) were not made during residency or to cover costs incurred after completion of medical school; (c) are not currently in default; (d) do not have an existing obligation to provide service for loan forgiveness through another program; (e) are not subject to repayment through another student loan repayment or loan forgiveness program; and (f) are not education loans made to myself from my own insurance policy or pension plan or from the insurance policy or pension plan of my spouse or other relative.
2. I understand that (a) upon acceptance of the application, all information submitted with the application becomes subject to disclosure under the Texas Public Information Act (Texas Government Code Section 552.001 et seq.), unless an exception under the Texas Public Information Act is applicable and (b) the Physician Education Loan Repayment Program disbursements are made annually after completion and verification of 12 months of continuous eligible service and are contingent upon the availability of funds.
3. The information contained in all parts of this application is true and correct to the best of my knowledge.

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.

TEXAS HIGHER EDUCATION COORDINATING BOARD

Physician Education Loan Repayment Program

Service Verification

Section A: Participant's Authorization to Release Employment Information – To be completed by the physician

Name:_____ Any Prior Name(s):_____

Last Four Digits of Social Security #:_____ Date of Birth: _____

Name of Employer:_____

Facility Name:_____

Facility Street Address:_____ Facility Phone #: _____

_____ Facility County:_____

City State Zip Code

I authorize the employer named above to release information regarding my employment to the Texas Higher Education Coordinating Board.

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.

Section B: Verification of Service – To be completed by the facility's Chief Administrator

Beginning Date of Employment _____with continuous service through _____.

Physician's Practice Specialty: _____.

This physician is ☐ board certified ☐ eligible to take the exam for board certification ☐ neither

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 per week. Eligible part-time service for those with a minimum of 20 hours of eligible direct patient care will be pro-rated. ***Do Not Include Precepting Time or On-Call Time.***

Total hours per week at this facility: _____

Hours per week providing direct patient care at this facility: _____

State the number of sites at which services are provided: _____
(Please note that a separate form is required for each physical location.)

Does this physician serve patients who are: (1) enrolled in Medicaid, (2) uninsured, (3) enrolled in Medicare, except in the case of pediatricians, and (4) enrolled in CHIP, if the practice serves patients under the age of 21? ☐ Yes ☐ No

Estimated number of patients enrolled in Medicaid and CHIP who were treated by the physician during the service period: _____

I certify that the physician named in Section A has provided the services described above at the facility indicated and the information provided on this form is true and correct.

_____ _____ _____
Signature of Chief Administrator Printed Name and Title of Chief Administrator Date

_____ _____ _____
Phone E-mail Address Fax

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.

TEXAS HIGHER EDUCATION COORDINATING BOARD

Physician Education Loan Repayment Program

Authorization to Release Student Loan Information

Participant Information

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

Participant Authorization

I have applied for loan repayment through 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**: _____