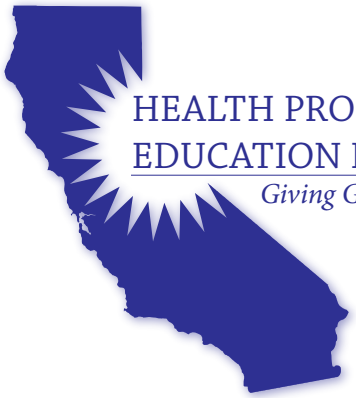
Enclosure 2



Applicant's County of Employment:_____

# Mental Health Loan Assumption Program Application

## Application Postmark Deadline is *January 24, 2010*

**Please note that the County Employment or Volunteer Verification Form must be submitted directly to the County Mental Health Director by *December 10, 2009.* This form will then be forwarded to the Foundation.**

## *Giving Golden Opportunities by:*

*Increasing the supply of mental health practitioners in underserved areas*

*Improving access to healthcare in rural and urban areas of California*

*Awarding mental health practitioners who are dedicated to practicing in underserved communities*

# Application Instructions

**You must be a California resident and a citizen or permanent resident of the U.S. to apply.**

The Health Professions Education Foundation (Foundation) and the Department of Mental Health (DMH) recognize the necessity of addressing conditions which create healthcare disparities in the state. At the same time, the Foundation acknowledges the difficulty of retaining mental health providers in the Public Mental Health System because of the heavy debt load carried from acquiring a higher education degree. The Mental Health Loan Assumption Program (***MHLAP***) encourages mental health providers to practice in underserved locations in California by authorizing a plan for repayment of some or all of their educational loans in exchange for their service in a designated hard to fill or retain position in the Public Mental Health System.

The MHLAP is jointly administered by DMH and the Foundation. The MHLAP is funded through the Workforce, Education, and Training component of the Mental Health Services Act (MHSA). California voters passed the MHSA in November 2004 to strengthen the Public Mental Health System by providing increased funding, personnel and other resources to support county mental health programs and to monitor progress towards statewide goals.

The ***MHLAP*** initially repays up to $10,000 in outstanding government or commercial educational loans for expenses incurred for undergraduate and graduate education. Prior award recipients may reapply for an additional award of up to $10,000. An awardee may receive up to $60,000 over a total of 72 months depending on the availability of funds. The loan assumptions will not exceed the amount of the participant's outstanding educational loan balances.

## QUALIFIED FACILITIES

When submitting an application, the applicant must already be working at or must have entered into an agreement to begin work in the Public Mental Health System.

"Public Mental Health System" means publicly-funded mental health programs/services and entities that are administered, in whole or in part, by DMH or the County. It does not include programs and/or services administered, in whole or in part, by federal, state, county or private correctional entities or programs and/or services provided in correctional facilities. The facility must be contracted or sub-contracted with DMH or the County.

## LOAN ASSUMPTION AWARDS

The Foundation, under the ***MHLAP***, is authorized to repay outstanding educational loans held by educational lending institutions. Educational loans obtained for the education of anyone other than the applicant are not eligible for repayment. Award recipients are responsible for making continued loan payments during the course of their participation in the ***MHLAP***. Payment(s) will be made directly to lender(s) at the end of each 12 consecutive months of paid or unpaid employment.

Participants may receive up to $10,000 in exchange for 12 consecutive months of employment in a designated hard to fill or retain position in the Public Mental Health System. Loan assumption award recipients will be required to sign a written contract with the Office of Statewide Health Planning and Development/Health Professions Education Foundation (OSHPD/Foundation) outlining the provisions which must be met to fulfill the obligations under this program. In no event shall the amount of the educational loan assumptions exceed the amount of the cumulative participant's outstanding educational loan balances as of the date the written contract is signed between OSHPD/Foundation and the award recipient.

## LOAN ASSUMPTION ELIGIBILITY

"Mental health providers" means a licensed psychologist, registered psychologist, postdoctoral psychological assistant, postdoctoral psychological trainee, licensed marriage and family therapist, marriage and family therapist intern, licensed clinical social worker, associate clinical social worker, licensed psychiatrist, registered psychiatrist, licensed or certified psychiatric mental health nurse practitioner or registered psychiatric mental health nurse practitioner.

Loan assumption awards are available to mental health service providers who maintain satisfactory employment in a "hard to fill or retain" position in the Public Mental Health System, which will be determined and verified by their corresponding County Mental Health Director or his/her designee.

Mental health providers awarded under this program must complete a minimum 12 consecutive month service obligation and maintain either full-time or part-time employment. "Full-time" means working for 40 hours per week or the equivalent of, for a minimum of 45 weeks per year. "Part-time" means a minimum of 20 hours per week for a minimum of 45 weeks per year. Special consideration will be given to persons who are experiencing involuntary furloughs or work hours impacted by budget cuts.

## LOAN ASSUMPTION REQUIREMENTS

Payment shall be made on the award recipient's behalf after 12 consecutive months of paid or unpaid employment and current balance of the loans have been verified by the Foundation. Payment(s) shall be made directly to the lending institution(s) holding the educational loan(s), as identified in the recipient's application. Award recipients may re-apply annually for a maximum of up to 72 months total and $60,000, pending the availability of ***MHLAP*** funds. Approximately $2.6 million will be available in Fiscal Year 2009-10. DMH determines the funding available for each county for awards. To view a list of these allocations, go to http://www.dmh.ca.gov/DMHDocs/2009_Notices.asp.

## CHANGE IN PRACTICE LOCATION

Should an award recipient change practice location prior to the end of their 12 consecutive months of service, the County and Foundation shall verify the participant's compliance with all requirements of the ***MHLAP.*** Any award recipient who changes County of employment or who does not comply with his/her loan assumption contract shall be removed or suspended from the program.

# Application Instructions (cont.)

## SELECTION CRITERIA

The most qualified applicants in each county who are employed in hard-to-fill/retain positions in the Public Mental Health System will be selected. Priority consideration will be given to applicants best suited to meet the cultural and linguistic needs and demands of mental health consumers, based on the applicant meeting one or more of the following criteria:

- **Work Experience** – Mental health work experience in the Public Mental Health System
- **Cultural and Linguistic Competence** – The applicant's interest and ability to understand and respond effectively to the cultural and linguistic needs of consumers of mental health services
- **Fluency** – Fluency in a language other than English must be verified on the County Employment or Volunteer Verification Form. The County Mental Health Director or designee must then verify that the applicant's language skills are needed in that county
- **Personal and Community Background** – Life experiences, socio-economic background, and community in which the applicant was raised
- **Community Service** – Community service, volunteer activities and/or professional organization membership
- **Career Goals** – Professional goals for the next five to ten years

Priority consideration will be given to those applicants whose background and commitment indicates the likelihood of long-term employment in the Public Mental Health System even after the service obligation has ended.

## SUBMIT THE FOLLOWING

Please do not staple any portion of the application.

**1. Completed Application**

Fill out pages one and two of the application. The pages must be completed, signed and dated to be considered eligible.

**2. Educational Debt Reporting Form**

All sections on page three of the application must be completed in order to identify all educational loans held by the applicant.

**3. Lender Statements**

Submit copies of the most recent lender statements (no more than six months old) for all educational loans. Statements must identify your name, the name of the lender, account number, balance owed, and address to which payments are submitted.

**4. Personal Statement**

Restate and number each question along with your answer. The questions can be found on page two of the application. The statement must be typed and no more than two pages total. Failure to respond comprehensively to the questions may result in your application being considered incomplete and thus, ineligible.

**5. County Employment or Volunteer Verification Form**

Page four of the application must first be signed by a supervisor or administrative officer who can verify the applicant's work hours, primary responsibility, and language abilities. This form must then be signed by the applicant's County Mental Health Director or designee stating that the applicant is or will be employed in a hard to fill or retain position within the Public Mental Health System. A complete list of the Directors and designees can be found at http://www.dmh.ca.gov/docs/CMHDA.pdf. *It is the applicant's responsibility to submit the County Employment or Volunteer Verification Form to the County Mental Health Director by the deadline indicated on the cover of this application:* ***December 10, 2009***. The County Mental Health Director or designee will submit the County Employment or Volunteer Verification Form directly to the Foundation by January 24, 2010.

**6. Two Professional Letters of Recommendation**

Letters of recommendation must be signed and dated within six months of the application deadline and may come from the following sources: an applicant's current or previous employer, a representative from an organization at which the applicant has volunteered, an educational instructor, or the County Mental Health Director or designee. The letters must be on letterhead or include the author's name, title, mailing address, phone number, and relationship to the applicant.

**7. Proof of Licensure, Registration, or Waiver**

A copy of a document which includes a license number, registration number, unique ID number or waiver issued by the California Board of Psychology, California Board of Behavioral Sciences, Board of Registered Nursing, Medical Board of California, or the Department of Mental Health. Documents may be verified by Foundation staff to ensure that the applicant is in good standing.

## QUESTIONS ABOUT THE APPLICATION

For assistance, please call the Health Professions Education Foundation at (800)773-1669 or (916) 326-3640.

## APPLICATION SUBMISSION

Applications and all supporting documentation must be postmarked by the deadline of January 24, 2010. In order to be reviewed, each part of the application must be completed.

## NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results within 120 days of the final filing date.

## POSTMARK DEADLINE: JANUARY 24, 2010

**Submit applications to:**

**Health Professions Education Foundation**

**Mental Health Loan Assumption Program**

**400 R Street, Suite 460**

**Sacramento, CA 95811**

# Application

_____, _____
Last Name First Name

**Please enter the amount you are requesting (up to $10,000):** _____

Please refer to the application instructions when completing the application. Complete all pages of the application form, and make sure all supporting documents are submitted with your application with the exception of the County Employment or Volunteer Verification Form which needs to be submitted directly to the County Mental Health Director or his/her designee by December 10, 2009. All documents must be postmarked by the application deadline. Late or incomplete application packets will not be evaluated.

## PART A - PERSONAL INFORMATION (Please type or print your answers legibly in the space provided.)

Note that all personal and identifying information provided will remain private and confidential and will not be disclosed outside the MHLAP award process.

| | | | |
|---|---|---|---|
| ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. | Last Name: | First Name: | Middle Initial: |
| CA Driver's License Number: | | *Social Security Number: | |
| Mailing Address: | | | |
| City: | | State: | Zip: |
| County: | | | |
| Permanent Address (if different than above): | | | |
| City: | | State: | Zip: |
| County: | | | |
| Home Phone: ( ) | | Date of Birth: | |
| Cell Phone: ( ) | | E-mail Address: | |
| Work Phone: ( ) | | Gender: ☐ Male ☐ Female ☐ Other | |
| Are you a citizen or permanent resident of the U.S.? ☐ Yes ☐ No | | Are you a California resident? ☐ Yes ☐ No | |
| With which CA Board are you registered or licensed? ☐ Behavioral Science ☐ Psychology ☐ Medical Board ☐ Registered Nursing | | | |
| License, Registrations, or Waiver # (if applicable): | | | |

What is your mental health profession? ☐ Licensed Marriage & Family Therapist ☐ Marriage & Family Therapist Intern

☐ Licensed Psychiatrist ☐ Registered Psychiatrist ☐ Licensed Clinical Social Worker ☐ Associate Clinical Social Worker

☐ Licensed/Certified Psychiatric Mental Health Nurse Practitioner ☐ Registered Psychiatric Mental Health Nurse Practitioner

☐ Licensed Psychologist ☐ Registered Psychologist ☐ Postdoctoral Psychological Assistant ☐ Postdoctoral Psychological Trainee

### PERSONAL INFORMATION NOTIFICATION

The Information Practices Act of 1977 and the Federal Privacy Act require this program to provide the following to individuals who are asked by the Office of Statewide Health Planning and Development, Health Professions Education Foundation to supply information: The principal purposes for requesting personal information are for verification of identification, establishment of eligibility and program administration. Program regulations (Chapter 16 of Title 22 of the California Code of Regulations, Sections 97900 et seq.) require every individual to furnish appropriate information for application to the Mental Health Loan Assumption Program. All requested information is required unless it is specifically identified as voluntary. Failure to furnish this information may result in the application being deemed as incomplete and thus ineligible. An individual has a right of access to records containing his/her personal information that are maintained by the Office of Statewide Health Planning and Development, Health Professions Education Foundation. The person responsible for maintaining the information is the Executive Director, Health Professions Education Foundation, 400 R Street, Room 460, Sacramento, CA 95811, (916) 326-3640. The Foundation may charge a small fee to cover the cost of duplicating this information.

### COMMENTS:*MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBERS

Disclosure of your U.S. Social Security Number is mandatory. Section 30 of the Business and Professions Code and Public Law 94-455 (42USCA 405(c)(2)(C)) authorize collection of your social security number. Your social security number will be used exclusively for tax enforcement purposes, for purposes of compliance with any judgment or order for family support in accordance with Section 17520 of the Family Code, or for verification of licensure or examination status by a licensing or examination entity which utilizes a national examination and where licensure is reciprocal with the requesting state. If you fail to disclose your social security number, your application will not be processed AND you will be reported to the Franchise Tax Board, which may assess a $100 penalty against you.

# Application (cont.)

MHLAP



_____, _____
Last Name First Name

## PART B – WORK EXPERIENCE

1. Do you work in the Public Mental Health System? ☐Yes ☐No

2. How many years have you worked in the Public Mental Health System?
_____ years

3. Do you currently provide direct client care in or through the Public Mental Health System? ☐Yes ☐No

4. How many hours a week of direct client care do you provide?
_____ hours/per week

## PART C – COMMUNITY BACKGROUND

If you answer "yes" to the following question, please elaborate in your Personal Statement.

1. Have you ever lived in an economically disadvantaged situation, such as having an income below the federal poverty level, low income, subsidized income, qualifying for public programs, or living in a rural community or inner city for at least two (2) years? ☐Yes ☐No

## PART D – PERSONAL STATEMENT

Your statement must be typed and no more than two pages total. Number and re-type each of the six questions below along with your answer. Failure to respond comprehensively to the questions may result in your application being considered incomplete and ineligible. Only the first two pages of your Personal Statement will be read and scored.

1. If you indicated in Part C that you have been economically disadvantaged, please elaborate.
2. Describe/explain your interest in working in an underserved community, such as a cultural, linguistic or geographic group.
3. Describe how your life experience and/or training have prepared you to understand and respond effectively to the cultural and linguistic needs of the community you serve.
4. How has your life experience and/or training prepared you to work with mental health consumers?
5. Describe any community service, volunteer activities, and/or professional organization memberships in which you have been involved for the past three (3) years. Please include a description of your role and the length of time you have been committed to these groups.
6. What are your professional goals for the next five (5) to ten (10) years, as they relate to a mental health profession?

## PART E – QUESTIONNAIRE

1. Are you a previous awardee of the Foundation? ☐Yes ☐No
If yes, please enter the contract # _____

2. Do you currently owe a service obligation to another entity? ☐Yes ☐No

*"Service Obligation" means the contractual obligation agreed to by the recipient of a loan repayment or stipend where the recipient agrees to practice their profession for a specified period of time in or through a designated facility. This includes, but is not limited to, CalSWEC or other MHSA stipend programs.*

3. The Foundation also offers the Licensed Mental Health Service Provider Education Program which repays educational debt and is funded by professional licensure renewal fees. Would you like your application to be considered for the upcoming cycle of this program if you are not selected to be an award recipient for the ***LMHSPEP?***
☐Yes ☐No

4. How did you hear about the ***MHLAP***? (Check all that apply)

☐Work (employer or co-worker) ☐Friend/Acquaintance
☐TV ☐Radio ☐Foundation Web site
☐Other Web site ☐Advertisement
☐Newspaper or publication (please specify) _____
☐Organization or Affiliation (please specify) _____
☐Other source (please specify) _____

5. How did you receive the ***MHLAP*** application? (Check only one)

☐Program Director/Instructor ☐Foundation office
☐Foundation Web site ☐Other Web site
☐Work (employer/co-worker) ☐Friend/Acquaintance
☐Other (please specify) _____

## PART F – APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written contract with a practice setting committing to a minimum one year of full-time or part-time practice in the Public Mental Health System. I authorize the Foundation to verify any information submitted as part of this application. I understand that falsification of information contained in this application will disqualify my application. I understand that once submitted my application and supporting documents become the rights of the Foundation. I also understand that my application becomes the property of the Foundation and selected non-confidential information may be used, including but not limited to, advertising/marketing, program reports, newsletters, and other publications.

**Name (please print)**

Last Name: _____

First Name: _____ Middle Initial: _____

Applicant's Signature: _____

Date: _____

## SUBMISSION CHECKLISTS

**Postmark to County Mental Health Director or designee by December 10, 2009:**

☐ 1. County Employment or Volunteer Verification Form

**Postmark to Foundation by January 24, 2010:**

☐ 1. Completed Application
☐ 2. Educational Debt Reporting Form
☐ 3. Lender Statements
☐ 4. Personal Statement
☐ 5. Two Professional Letters of Recommendation
☐ 6. Proof of Licensure, Registration, or Waiver

# Educational Debt Reporting Form

MHLAP



**INSTRUCTIONS:**

**1. All spaces must be completed on this form, even if the information appears on the lender statements. Any missing information will make the application incomplete and ineligible.**

**2. Submit current lender statements (dated within 6 months) for the educational debts listed below. They must include the current balance, account number, your name, the name of the lender, and address to which payment is submitted.**

**Total Educational Debt Owed:**_____

## LOAN 1

School Attended: _____

Loan Account #: _____ Lending Institution: _____

Lender's Payment Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

## LOAN 2

School Attended: _____

Loan Account #: _____ Lending Institution: _____

Lender's Payment Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

## LOAN 3

School Attended: _____

Loan Account #: _____ Lending Institution: _____

Lender's Payment Address: _____

City: _____ State: _____ Zip: _____

Outstanding Balance: $ _____ Monthly Payment: $ _____

# County Employment or Volunteer Verification Form

MHLAP



**PART 1**: This portion of the form must be completed by a direct **supervisor** who can verify the applicant's hours.

Applicant's Name: _____

Job Title/Classification: _____

On a weekly basis, how many hours per week (average) does/will the applicant spend providing the following services:

Face-to-face interaction: _____ Administration: _____ First Line Supervision:_____ Management: _____

Average Weekly Hours Worked _____ ☐ F/T or ☐ P/T Start Date: _____/_____/_____

Employment or Volunteer Facility/Agency Name: _____

Program Name: _____ MHSA-funded Program: ☐ Yes or ☐ No

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Please describe the applicant's primary program responsibilities or job functions: _____

_____

_____

_____

I verify that the applicant can fluently speak the following language(s) in a work setting: _____

Which best describes the applicant's ethnic background? (optional): ☐ African American ☐ White, non-Hispanic ☐ Asian American

☐ Native American ☐ Pacific Islander ☐ Hispanic/Latino ☐ Other (Please specify) _____

I certify that I am the supervisor or administrative officer at this facility and that the facility will pay the applicant (if in a paid capacity) prevailing wages and that I agree not to use the Program's award of educational loan repayments as a means to reduce the recipient's salary or offset those salaries (e.g., deduction of funds from paychecks, etc.).

Supervisor Name: (Please Print) _____

Title: _____ Phone Number: _____

Email: _____ Fax Number: _____

Supervisor Signature: _____Date: _____

**PART 2:** This portion of the form must be completed by the County Mental Health Director or his/her designee.

**ELIGIBILITY:** The applicant is employed in a hard to fill/retain position in the Public Mental Health System. ☐ **YES** ☐ **NO**

**LANGUAGE:** The applicant possesses language skills which are needed to serve mental health consumers in our County ☐ **YES** ☐ **NO**

Director or Designee Name: (Please Print) _____

County: _____ Phone Number: _____

Email: _____ Fax Number: _____

Director or Designee Signature: _____ Date: _____

HEALTH PROFESSIONS
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Revised 10-14-2009