Center of Excellence in Rural Health

Kentucky Behavioral Health Workforce Initiative Provider Application (New)

KORH Kentucky Office of Rural Health

PERSONAL INFORMATION			
First Name	Last Name		Middle Initial
Home Address			
City	State	Zip Code	County
Mailing Address (If different from above)			
City	State	Zip Code	County
Home Phone		Work Phone	
E-mail Address			
Date of Birth		Social Security Number	
How did you find out about the Kentucky Behavioral Health Workforce Initiative? (Check all that apply)		☐ College/University Faculty and Staff ☐ Conference Exhibit ☐ Employer ☐ Friend/Colleague ☐ Kentucky Office of Rural Health Website ☐ Kentucky Office of Rural Health Weekly Update ☐ Online Search ☐ Other: _____	

The following demographic information is being collected strictly for federal reporting purposes:

Gender	☐ Male	☐ Female	
Ethnicity	☐ Hispanic/Latino	☐ Not Hispanic/Latino	
Race	☐ American Indian or Alaska Native	☐ Black or African American	☐ Native Hawaiian or Other Pacific Islander
	☐ Asian	☐ Hispanic or Latino	☐ White

PROFESSIONAL INFORMATION

Provider Type

- ☐ Doctor of Allopathic Medicine (MD)
- ☐ Doctor of Osteopathic Medicine (DO)
- ☐ Physician Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Certified Nurse-Midwife (CNM)
- ☐ Alcohol and Substance Abuse Counselor
- ☐ Licensed Clinical Social Worker (LCSW)
- ☐ Licensed Professional Clinical Counselor (LPCC)
- ☐ Health Service Psychologist (HSP)
- ☐ Marriage and Family Therapist (MFT)
- ☐ Psychiatric Nurse Specialist (PNS)

Specialty (If applicable)

Name of Professional School Attended

Professional School Address

City	State	Zip Code	Country

Date of Graduation

Name of Residency Program (If applicable)

Residency Program Address

City	State	Zip Code	Country

Date of Completion

Are you board certified? ☐ Yes ☐ No

Are your board eligible? ☐ Yes ☐ No

NPI#

Name of Board	Date of Certification
License Type	Date Issued
State Where License Issued	License Expiration Date

License Number	Restriction

Has your license ever been restricted or revoked in any state? ☐ Yes ☐ No

If yes, please explain:

Do you have any professional disciplinary actions pending in any state? ☐ Yes ☐ No

If yes, please explain:

PRACTICE SITE

I ☐ have signed ☐ will sign *an agreement to work at the following practice site:*

Name of Practice Site			
Practice Site Address			
City	State	County	Zip Code
Name of Practice Site Contact		Phone Number for Practice Site Contact	
E-mail Address for Practice Site Contact			
Name of Parent Organization (If applicable)			
Parent Organization Address			
City	State	County	Zip Code

Are you willing to accept students on rotation as a Preceptor or Clinical Supervisor, if permitted and applicable? ☐ Yes ☐ No

PROFESSIONAL REFERENCES

Please provide the contact information for three (3) professional references — people who are familiar with and can speak about your abilities in the health care industry.

Name		
Mailing Address		
City	State	Zip Code
Phone Number	E-mail Address	
Relationship to Applicant		

Name		
Mailing Address		
City	State	Zip Code
Phone Number	E-mail Address	
Relationship to Applicant		

Name		
Mailing Address		
City	State	Zip Code
Phone Number	E-mail Address	
Relationship to Applicant		

AFFIRMATION OF ELIGIBILITY CRITERIA	
Please initial next to each statement indicating your confirmation that you meet each of the following Kentucky Behavioral Health Workforce Initiative eligibility criteria:	
I am a U.S. citizen (either U.S. born or naturalized) or U.S. National and reside in Kentucky.	
I have a current, full, permanent, unencumbered, unrestricted professional license, certificate, or registration in Kentucky in the discipline in which I am applying to serve.	
I am employed at an eligible KBHWI site, or have accepted an offer of employment at an eligible site where service will begin (and I will begin seeing patients) no later than January 1, 2023.	
I agree to practice full time, as defined by a minimum of 40 hours per week for a minimum of 45 weeks per year, providing primary health services at an eligible site.	
I agree to use KBHWI funds only to repay qualifying loans.	
I have no existing service obligation — nor will I incur any service obligation — that would be performed concurrently with, or overlap with, my KBHWI service obligation.	
I am not in default on any federal payment obligations (e.g., Health Education Assistance Loans, Nursing Student Loans, federal income tax liabilities, Federal Housing Authority loans, etc.) or any non-federal payment obligations (e.g., court-ordered child support payments or state tax liabilities), even if the applicant is currently considered to be in good standing by that creditor.	
I have not had any federal or non-federal debt written off as uncollectible or received a waiver of any federal service or payment obligation.	
I have not breached a prior service obligation to the federal government, a state or local government, or other entity, even if the applicant subsequently satisfied that obligation through service, monetary payment, or other means.	
I have no judgment liens arising from federal debt.	
I am not currently excluded, debarred, suspended, or disqualified by a federal agency.	

ESSAY QUESTION

Respond to the following prompt in 300-500 words:

Describe how your personal, academic, and/or employment history have prepared you to work with underserved rural and/or urban populations. Please provide concrete examples. Be sure to include in your response a discussion of your own personal motivation for working with underserved rural and/or urban populations in Kentucky, as well as a discussion of how working in a Mental Health Professional Shortage Area (MHPSA) figures into your long-term career goals.

PROGRAM OBLIGATIONS

I understand that, if approved to participate in the Kentucky Behavioral Health Workforce Initiative, I must fulfill the following obligations:

- Practice (work full-time) in a Mental Health Professional Shortage Area (MHPSA) determined by the health care organization co-sponsoring the loan repayment for the duration of the loan repayment obligation;

- Will not, in the case of a patient seeking care, discriminate on the basis of the individual's ability to pay for care or on the basis that payment for care will be made pursuant to the programs established in Title XVIII or Title XIX of the Social Security Act;

- Accept assignment under 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 of such Act, and will enter into an appropriate agreement with the state agency that administers the state plan for medical assistance under Title XIX of such Act to provide services to individuals entitled to medical assistance under the plan; and,

- The recipient will provide to the Kentucky Behavioral Health Workforce Initiative a copy of his/her annual license certification renewal form and will report semi-annually by letter the name, location and nature of practice to the community organization(s). The report will include a copy of the agreement with the recipient under Title XVIII of the Social Security Act in which the recipient agrees to accept assignment of patients served under Title XVIII.

I certify that the information given in this application and attachments is accurate and complete to the best of my knowledge. I hereby authorize the Kentucky Office of Rural Health to contact references and program directors listed in the application for the purpose of obtaining information about my professional qualifications and experience. I understand that the information I have provided is subject to verification, and willfully providing false information will result in disqualification from participation in this program. I understand that signing this document does not establish a contractual agreement between myself and the Kentucky Behavioral Health Initiative.

Printed Name	Date
Signature	