ATTACHMENT 1

HEALTH PROFESSIONS
EDUCATION FOUNDATION
Giving Golden Opportunities

CALIFORNIA DEPARTMENT OF
MENTAL HEALTH

Mental Health Loan Assumption Program

Qualified applicants may receive up to $10,000 in educational loan repayments from the Mental Health Loan Assumption Program in exchange for a 12-month service obligation working or volunteering in a hard-to-fill or retain position in the County Public Mental Health System.

Eligible Professions

Licensed Marriage & Family Therapists
Marriage & Family Therapist Interns
Licensed Clinical Social Workers
Associate Clinical Social Workers
Licensed Psychologists
Registered Psychologists
Postdoctoral Psychological Assistants
Postdoctoral Psychological Trainees
Licensed Psychiatrists
Registered Psychiatrists
Licensed Psychiatric Mental Health Nurse Practitioners
Certified Psychiatric Mental Health Nurse Practitioners
Registered Psychiatric Mental Health Nurse Practitioners
Licensed Professional Crinical Counselors
Counties may determine if other professions fit their hard-to-fill/retain criteria

To be eligible to participate in the MHLAP, applicants must:

Have valid legal presence and ability to work and provide care in the state of California,
Have no outstanding service obligation to an award or stipend program other than the Foundation,
Submit a complete application that is postmarked on or before December 10, 2011,
Have outstanding educational debt from a commercial or governmental lending institution,
Work or volunteer in the County Public Mental Health System for a minimum of 20 hours per week.

The Health Professions Education Foundation: www.healthprofessions.ca.gov or (800) 773-1669

Application Postmark Deadline: December 10, 2011

Faxes and emails will not be accepted.

This program is supported by funds secured from the MHSA in partnership with the California Department of Mental Health

Mental Health Loan Assumption Program Application

Application Postmark Deadline:

December 10, 2011

Applications or other required documents postmarked after December 10, 2011 will not be reviewed. Faxes will not be accepted.

Giving Golden Opportunities by:

Increasing the supply of mental health providers in underserved areas

Improving access to healthcare in rural and urban areas of California

Awarding mental health providers who are dedicated to practicing in underserved communities

MHLAP is funded through the Workforce Education and Training component of the Mental Health Services Act (MHSA).

Program Background and Eligibility

OVERVIEW

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/retain position in the Public Mental Health System. The MHLAP is jointly administered by the Health Professions Education Foundation (Foundation) and the Department of Mental Health. It 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 Agencies, and to monitor progress towards statewide goals.

BEFORE YOU APPLY, CHECK YOUR ELIGIBILITY!

To be eligible to participate in the MHLAP, you must:

- Have valid legal presence and ability to work in the state of California
- Have no outstanding service obligation to an entity other than the Foundation
- Have outstanding educational debt from a commercial or U.S. governmental lending institution
- Work or volunteer in the Public Mental Health System for a minimum of 20 hours per week
- Submit a complete application that is postmarked on or before December 10, 2011
- After submission of the application, be verified as working in a hard-to-fill/retain position in the Public Mental Health System by your County Mental Health Director.

WHERE DO I NEED TO WORK OR VOLUNTEER?

When submitting an application, you must be working in or have entered into an agreement to begin work in the Public Mental Health System. The Public Mental Health System includes publicly funded mental health programs/services and contractor services that are administered, in whole or in part, by County Mental Health Agencies. It does not include programs and/or services administered, in whole or in part, by federal, state, county or private correctional entities or programs or services provided in correctional facilities.

WHAT IS THE COUNTY PUBLIC MENTAL HEALTH SYSTEM?

Publicly-funded mental health programs/services that are administered, in whole or in part, by County Mental Health agencies including contractor services. Applicant must work for a County Mental Health Department or in a contract agency in a program funded by County mental Health. The PMHS does not include programs and/or services administered, in whole or part, by federal, state, county, or private adult correctional entities or programs or services provided in adult correctional facilities.

WHAT PROFESSIONS ARE ELIGIBLE?

"Mental health provider" includes, but is not limited to, licensed psychologist, registered psychologist, postdoctoral psychological assistant, postdoctoral psychological trainee, licensed clinical professional counselor, 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, registered psychiatric mental health nurse practitioner or a mental health administrator. County Mental Health Directors may determine if other professions fit their County's hard-to-fill/retain criteria.

HOW MUCH WOULD YOUR AWARD BE?

If awarded, you may receive up to $10,000. In no event shall the amount of the award exceed the amount of your outstanding educational debt. Payment(s) will be made directly to your lender(s) at the end of 12 consecutive months of service.

WHAT IF MY PRACTICE LOCATION CHANGES?

Your new practice location must meet the hard-to-fill/retain criteria in the same county where the original award was made. If the new practice location is in a different county, the award shall be terminated. If you change county of employment, no longer work in a hard-to-fill/retain approved position or your job does not comply with your contract, you shall be removed or suspended from the program.

WHAT IS THE SELECTION CRITERIA FOR THE AWARD?

The selection criteria will include the following:

Cultural and Linguistic Competence - See definition on next page.

Language Skills - Do you possess language skills that are needed to serve the mental health consumers in the County of employment.

Personal Background - How your life experiences, geographic, socio-economic background and the community in which you were raised impacted your desire or decision to work with public mental health systems.

Community Service - What community involvement or unpaid service you provide to your community and the population you serve.

Professional Goals – Your professional goals for the next five years and a demonstrated commitment to long-term employment in the Public Mental Health System.

WHAT DOES A VALID LEGAL PRESENCE MEAN?

Legal presence means that a person is a citizen or permanent legal resident of the United States or is otherwise legally present in the United States under federal immigration laws.

Please do not staple any portion of the application.
This page does not need to be included with your application.

Frequently Asked Questions

WHAT IS AN ADMINISTRATIVE POSITION?
Non-direct client care positions within the Public Mental Health System may be eligible to receive an MHLAP award, so long as the County Mental Health Director designates the position as hard-to-fill or retain.

WHAT IS THE MHLAP CONTRACT?
You will need to sign a written agreement between the Office of Statewide Health Planning and Development/ Foundation and a participant in the loan repayment program that obligates the participant, in exchange for financial assistance, to practice his or her profession for a specified period of time in a hard-to-fill/retain position in the Public Mental Health System.

WHO IS YOUR COUNTY MENTAL HEALTH DIRECTOR?
Pursuant to Title 9 of the California Code of Regulations Section 3852(c), the County Mental Health Director or designee must certify that each applicant is employed in a Public Mental Health System position that is hard-to-fill or in which it is hard to retain staff to be eligible for MHLAP. The Foundation will forward your application to the County Mental Health Director or his/her authorized designee. You will find contact information for your County Mental Health Director or Designee at www.healthprofessions.ca.gov/mhlap.

WHAT IS CULTURAL COMPETENCE?
Cultural competence aims to address the needs and demands of individuals with lived experience as well as racial/ethnic, cultural, socio-economic, geographic, linguistic and religious populations or communities by:

- Providing equal access to quality services;
- Meaningfully including consumers and family members in incorporating their viewpoints and experiences in all aspects of service delivery;
- Effectively engaging individuals of different backgrounds;
- Understanding the impact bias, racism, and other forms of discrimination have on how people perceive mental health service delivery and adjusting service delivery to take that understanding into account.

WHAT ARE ELIGIBLE EDUCATIONAL LOANS?
Government (Federal, State, or local) and commercial loans obtained by the recipient for school tuition, reasonable educational expenses, and reasonable living expenses. Certain types of debt are not eligible for repayment, such as international loans, lines of credit, home equity loans, credit card debt, business loans, mortgages, and personal loans.

WHAT IS LINGUISTIC COMPETENCE?
Organizations and individuals working within the system able to communicate effectively and convey information in a manner that is easily understood by diverse audiences, including individuals with Limited English Proficiency; individuals who have few literacy skills or are not literate; and individuals with disabilities that impair communication.

WHAT IS LGBTQ?
Refers to individuals who self-identify as “lesbian, gay, bisexual, transgender, inter-sex, two-spirit and questioning” and is intended to emphaisize a diversity of “sexuality and gender identity-based cultures” and is sometimes used to refer to anyone who is non-heterosexual.

WHAT IS AN AUTHORIZED ENTITY?
An “authorized entity” refers to a Department/Unit or person who can verify your employment and the number of hours you work.

WHAT IS THE MENTAL HEALTH SERVICES ACT (MHSA)?
The law that funds the MHLAP program took effect in 2005 when proposition 63 was approved by California voters and codified in the Welfare and Institutions Code.

DO I NEED FLUENECY IN A SECOND LANGUAGE?
You need to possess language skills that are needed to serve the mental health consumers in your County of employment. Your County Mental Health Director/designee decides whether a specific language is required to meet local workforce needs.

WHAT IS THE SERVICE OBLIGATION?
The contractual obligation you agree to if you are a recipient of an MHLAP award. You will be required to practice your profession for a 12-month period.

HOW LONG WILL THE SERVICE OBLIGATION BE?
You must complete a minimum 12 month consecutive or equivalent paid or unpaid service obligation and working or volunteering a minimun of 20 hours per week.

WHO ARE THE UNDERSERVED?
Clients who have been diagnosed with a serious mental illness and/or emotional disturbance and are receiving some services, but are not provided the necessary or appropriate opportunities to support their recovery, wellness and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client’s recovery, wellness and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas.

WHO ARE THE UNSERVED?
Those individuals who may have serious mental illness and/or serious emotional disturbance and are not receiving mental health services and/or those who, may have had only emergency or crisis-oriented contact with and/or services from the County.

Application Instructions

SUBMIT THE FOLLOWING

For your application to be considered eligible for MHLAP, each of the items listed below must be filled out completely ALL MATERIALS MUST BE POSTMARKED BY THE DEADLINE (application, lender statements and proof of license, registration or waiver).

1. PAGES 1-7 OF THE APPLICATION

- ☐ Fill in all spaces.
- ☐ All questions must be answered.
- ☐ List lenders on the Educational Debt Report (EDR) Part D, page 4 of the application. List in the order you wish them to be repaid.
- ☐ County Employment or Volunteer Verification, Part C, page 3 is to be completed and signed by your direct supervisor or an authorized entity who can verify the required information.
- ☐ The Application Certification and Letter of Understanding, Part I, page 7 must be signed and dated. If this page is not signed you will be disqualified.

2. LENDER STATEMENT(S)

- ☐ Lender's name should be on the statement. If you send your payment check to another company be sure to write in the name of the servicing company.
- ☐ Your name must be listed on each lender statement that is submitted. If the name on your lender statements do not match your legal name, please submit a copy of a marriage certificate or other documents which verify any name changes.
- ☐ Lender's name and payment address must be current and correct.
- ☐ The lender statement(s) must be dated within the last six months of deadline date.
- ☐ The current balance must match the balance on the debt reporting form, on page 4.
- ☐ Account numbers on the lender statements must match what is shown on page 4.

3. PROOF OF LICENSURE, REGISTRATION OR WAIVER

- ☐ If you are 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, registered psychiatric mental health nurse practitioner, licensed clinical professional counselor, and/or any other professional licensed by a California Board, you must Include your current, unencumbered, unrestricted health provider license, registration or waiver. If applicable, waivers are to be issued by California Department of Mental Health.

4. PERSONAL STATEMENT (Please make an effort to be legible).

- ☐ Use the space indicated on the page or enclose a 1 page statement. Do not send more than 1 page.

QUESTIONS ABOUT THE APPLICATION

For assistance, please call the Health Professions Education Foundation at (800) 773-1669 or (916) 326-3640. You will also find helpful information online at www.healthprofessions.ca.gov.

APPLICATION SUBMISSION

Applications and all supporting documentation are to be postmarked by the deadline of December 10, 2011. The Foundation encourages applicants to submit all materials 6 to 8 weeks early.

NOTIFICATION OF AWARDS

The Foundation will notify applicants of their application results. If selected to participate in the program, contracts will be sent to awardees by late May/early June. Please plan ahead so that the Foundation has contact information for you to be able to send contracts to you. Contracts will need to be returned no later than June 30, 2012.

SUBMIT ALL APPLICATION MATERIALS POSTMARKED ON OR BEFORE DECEMBER 10, 2011 TO:

Health Professions Education Foundation
Attn: MHLAP
400 R Street, Suite 460
Sacramento, CA 95811

Please do not staple any portion of the application.
This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Application

PART A - PERSONAL INFORMATION

Please type or print your answers legibly in the space provided. All personal and identifying information provided will remain private and confidential and will not be disclosed outside the MHLAP award process.

Driver License ID #: ____________________

First Name:__________________________**Initial**: __

Employment County :____________________

Mailing Address:

Street:_________________________________

City:___________________________________

County________________ St.___ Zip:________

Permanent Address (if different than above)

Street: ________________________________

City: __________________________________

County:_____________St. ____ Zip_________

Contact and Personal Information:

Home Phone:__________________________

Work Phone:__________________________

Cell Phone:___________________________

***Social Security #**:___________________________

Last Name:__________________________________

Date of Birth: (mm/dd/yyyy) ___________________

Gender: Male ☐ Female ☐ Other ☐

What best describes your ethnic background?

____

The Foundation utilizes this information for statistical purposes only.

Which California Board are you licensed or registered with? (Send in a copy of certificate with application)
Board name:_______________________________

Do you currently owe a service obligation to another award or stipend program (i.e. CalSWEC, County MHSA Stipend Programs, NHSC, or other)?
Yes ☐ No ☐ Dates:___________________

Are you a prior awardee of the Foundation?
Yes ☐ No ☐ Dates:___________________

E-Mail: (Mandatory)______________________

Emails must be legible; ensure that underscores are clearly distinguishable from dashes and numbers are distinguishable from letters. The Foundation will Communicate with you through the email address above. Please check this email frequently for communiques that may be time sensitive.

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. Title 22 of the California Code of Regulations, Sections 97900 et seq. and Title 9 of the California Code of Regulations, Sections 3100 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 will result in the application being deemed incomplete and 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.

***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.

Please do not staple any portion of the application.
This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Application (continued)

MHLAP

Last Name: ________________________

First Name: ________________________

PART B. PERSONAL, EDUCATIONAL AND PROFESSIONAL EXPERIENCES

1. How have your personal, educational and professional experiences contributed to your cultural or linguistic competence? Give a brief example only if a statement below applies to your experience. As part of your answer please identify the population/s you work with. Your examples must be on this page. No additional pages will be accepted.

A. Briefly explain how you have utilized the strengths and forms of healing unique to an individual's racial/ethnic, cultural, geographic, socio-economic, and linguistic population or community when providing services or support.

B. Tell us about your work, unpaid and paid, serving a particular racial/ethnic, cultural, geographic, socio-economic, LGBTQ, and/or linguistic population or community.

C. Give an example of how your life experiences and/or education have contributed to your cultural competency in serving the public mental health system in an urban or rural community.

D. Give an example of how you have participated in treatment interventions and outreach services to engage and retain individuals of diverse racial/ethnic, LGBTQ, cultural and linguistic populations.

E. Give an example of how your experiences, education or work with faith based communities have contributed to your competency in creating rapport with individuals with lived experience, few literacy skills, are not literate, or have disabilites that impair communication.

Please do not staple any portion of the application.
This page must be signed and dated by the applicant's direct supervisor or authorized entity.
Faxes will not be accepted.

Last Name: ________________________
First Name: ________________________

PART C. COUNTY EMPLOYMENT or VOLUNTEER VERIFICATION

Items A. through K. are to be completed by the applicant and/or the applicant's direct supervisor. This page must be signed and dated by the applicant's DIRECT SUPERVISOR or an AUTHORIZED ENTITY who can verify the applicant's information and hours.

A. **Employment or Volunteer Facility/Agency Name:** ____________________
Program Name: ____________________
Address: ____________________
City: ____________ State: ______ Zip: ________ County: ________

B. **Name of Supervisor or Authorized Entity:** ____________________
Title: ____________ Phone #: ____________ Email: ____________

C. **Applicant's Start Date: (mm/dd/yyyy)** ____________________

D. **Applicant fluently speaks the following language(s) needed in a work setting:** ____________

E. **How many hours per week (average) does/will the applicant spend providing the following services:**

Direct Care includes phone calls, group therapy or direct interaction with clients: _____ hours
Administrative: travel to/from clients, families, reports client support services: _____ hours
First line supervision of interns, assistants or trainees: _____ hours
Managerial or administrative tasks: _____ hours

Total weekly work or volunteer hours: (Mandatory) _____ hours

F. **Which best describes your ethnic background?** ____________________
(The Foundation will utilize this information for statistical purposes only)

G. **What is applicant's profession?** ____________________

H. **What is the applicant's job title?** ____________________

I. **Applicant's primary program responsibilities or job functions:** ____________________

____

J. **List the specific counties in which you 'yourself' provide care.**
County #1 ____________ County #2 ____________

K. **How many hours a week do you 'yourself' provide services in each County?**
County #1 ____________ County #2 ____________

I certify that I am the supervisor or authorized administrative officer at this facility/agency and that the facility/agency 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.). **I verify that the information provided on this page of the MHLAP application is true and accurate to the best of my knowledge.**

DIRECT SUPERVISOR or AUTHORIZED ENTITY SIGNATURE and DATE REQUIRED!

Signature: ______________________________ Date: ____________
Direct Supervisor or Authorized Entity Signature

Please do not staple any portion of the application.
This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Last Name: ___________________________
First Name: ___________________________

PART D. EDUCATIONAL DEBT REPORT (EDR)

Instructions:

1. ***All*** spaces must be completed on this form for each loan you have, ***even if the information appears on the lender statements.***
2. All of the requested lender information below should correspond with the lending institution and location where your payments are processed. If additional pages are required, please include them with the application.
3. Submit current lender statements (dated within 6 months) for loans # 1 -3 listed below. They must include the current balance, account number, your name, the name of the lender, and address to which payment is submitted. Enter loans in the order you would like them to be repaid.

Enter loans below in the order you would like paid.

LOAN 1 **Award payment would go to this loan.**

Lending Institution: ____

The name of the company/institution that you make your check payable to (if different than above):

____

Account Number: ____

Payment Address: ____

City: __________________ State: _________________ ZIP: ______________

Enter the Outstanding Balance: $__________________________________

LOAN 2 **If the balance on loan # 1 is less than $10,000, please fill this section in.**

Lending Institution: ____

The name of the company/institution that you make your check payable to (if different than above):

____

Account Number: ____

Payment Address: ____

City: ________________________ State: _____________________ ZIP: _________________________

Enter the Outstanding Balance: $____

LOAN 3 **If the total debt for loans # 1 and # 2 are less than $10,000 fill this section in.**

Lending Institution: ____

The name of the company/institution that you make your check payable to (if different than above):

____

Account Number: ____

Payment Address: ____

City: ________________________________ State: _____________ ZIP: _________________

Enter the Outstanding Balance: $____

OTHER **All other educational debt.**

How many other educational loans do you have besides the loans listed above? ____________

What is your total educational debt balance on these remaining loans? $____________________

THE FOUNDATION USES THE INFORMATION PROVIDED ON THIS FORM TO EXPLORE FUNDING OPPORTUNITIES TO INCREASE FUTURE AWARDS.

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Last Name:

First Name:

PART E. PROFESSIONAL GOALS

A. What type of organization do you see yourself working in in the next 5 years? Elaborate on your professional career goals as they relate to mental health profession. Use the space below. (Extra pages will not be accepted)

B. Prioritize the type of Community where you are interested in working for the next five years.

Check 2 of the following that most closely match your professional goals (1=highest priority, 2=lowest priority):

-- Anywhere in California

-- Outside of California

-- An underserved community

-- A specific cultural or linguistic group (please specify): ___________________

-- A specifc geographic group (please specify): __________________________

-- Other (please specify): ____

PART F. COMMUNITY SERVICE

In the table below, please list any community service, volunteer activities, and/or professional organization memberships in which you have been involved within the past five (5) years. If you have had no such service leave blank.

Community Service	Start - End Date	Your Role	Was this service paid or required by your employer?
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐
			Yes ☐ No ☐

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Application (continued)

Last Name: ______________________

First Name: ______________________

PART G. PERSONAL STATEMENT

Elaborate on how your personal background, education, training or lived experience as a consumer or family member in the mental health system has contributed to your commitment to working in the County Public Mental Health System and/or enabled you to better serve those you work with. (Use the space below or attach a one (1) page document to your application. Do not send more than one page as extra pages will not be considered).

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This page must be completed and submitted for your application to be considered complete. Faxes will not be accepted.

Last Name: ______________________

First Name: ______________________

PART H. PERSONAL CONTACTS

Provide three (3) personal contacts (preferably family members) so that we may reach you:

Name	Address-City-State-Zip	Primary Phone	E-mail

PART I.
APPLICATION CERTIFICATION

I certify that I am the person herein named submitting 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 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.

LETTER OF UNDERSTANDING

I understand that the Mental Health Loan Assumption Program is a financial incentive program designed to recruit and retain qualified professionals in hard to fill/retain positions in the Public Mental Health System. By submitting a complete application and signing this letter, I understand that I am not guaranteed an award. If selected to participate in the program, I agree to:

1. For the period of 6/30/12 through 6/29/13 provide permanent full-time or part-time service at the County Department of Mental Health or at an organization that contracts or subcontracts with the County Department of Mental Health. This does not include programs and/or services administered, in whole or part, by federal, state, county or private correctional facilities.
2. Remain in the same County of Employment, in a position that is approved by the County Mental Health Director as hard-to-fill/retain, until after my service obligation is complete.
3. Continue to make any required payments on all outstanding educational loans concurrent with any payment made by the OSHPD/Foundation.
4. Notify the Foundation in writing of any and all phone, address, name and educational lender changes within 30 day of the change. This includes any notification I may receive regarding lender payment address or lender name changes.
5. Notify the Foundation in writing to request any changes in practice location within 30 days prior to starting at the new practice location.
6. Submit all requested information during the duration of the 12 (twelve) month service obligation to the Foundation by required deadlines, including 2 (two) Employment Verification Forms, paystubs, and lender statements.
7. Only enter into one Contract or Agreement at any given time throughout the application process or period of service with the Foundation or any other loan repayment entities in exchange for financial assistance, tuition reimbursement, scholarship or a loan repayment.

Signature: ______________________________ **Date:** ____________________

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Health Professions Education Foundation

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Mental Health Loan Assumption Program

Linda Onstad-Adkins
Program Officer
Mental Health Loan Assumption Program

For additional information please refer to the Foundation website: www.healthprofessions.ca.gov

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