Maryland Higher Education Commission
Office of Student Financial Assistance

6 N. Liberty Street
Baltimore, Maryland 21201
410-767-3301; 800-974-0203

Maryland
DEPARTMENT OF HEALTH

Maryland Department of Health
Office of Oral Health

201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
410-767-3081

FYI: It is recommended that you are a Medicaid provider at the time of applying. The process for Medicaid numbers may take up to 90 days and could deem you ineligible if your Medicaid information is not available at time of application submission date.

Section A: Applicant Information

*** MDC-LARP awards are limited to one three-year award period. Previous recipients are not eligible for re-application.***

Last Name:	First Name:	MI:
Previous name under which records may have been kept:		
Address:		
City:	State:	Zip:
County:		(Home)
E-mail:		(Work)
		(Cell)
Social Security Number:		Date of Birth:
Maryland Dental License: YES ◯ NO ◯		License Number:

All valid Maryland dental licenses are issued by the Maryland State Board of Dental Examiners (MSBDE).

***** Must be Maryland Licensed by July 31, 2020 to be eligible for consideration. *****

Certification Statement

All the information on this application is true to the best of my knowledge. If asked by the Office of Student Financial Assistance or the Office of Oral Health, I will provide proof of the information I have given on this application.

I give permission for any information related to my application to the MDC-LARP to be shared with the members of the Review Panel in consideration for the MDC-LARP award.

Applicant Signature: _____ Date: _____

APPLICATION INSTRUCTIONS:

All application materials must be received by July 31Σ 2020.

This application form should be completed electronically and submitted via email to:

YŘK.mdclarpprogram@maryland.goØ

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We are requesting, as much if not all , application materials to be emailed . If you are unable to email some items - materials should be faxed to (410) 333πτοφнΣ ! űűyΦ a 5 /π[! wtΣ 2₦ ăŜyű ű2 űKŜ ₮2ff2ø/yƎ I-ŘŘ₦Ŝăăy

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Section B: Additional Applicant Information

ALL items must be answered for form to be complete

	Yes	No
1. Are you a Maryland resident? **If Yes, how long? #Year(s): ____ #Months: ____**	◯	◯
2. Are you a Medicaid provider currently? **If yes, what is your NPI Number? _____ Medicaid Number? _____**	◯	◯
3. Have you ever been charged or convicted of criminal activity other than a minor traffic violation?If "Yes", please explain:	◯	◯
4. Do you use illicit or illegal drugs?	◯	◯
5. Has your dental license ever been suspended? **If "Yes", please provide the date suspended and state the reason why.**	◯	◯
6. Has your dental license ever been revoked? **If "Yes", please provide the date revoked and state the reason why.**	◯	◯
7. Are you an American Dental Association (ADA) recognized specialist? **If "Yes", what specialty?**	◯	◯
8. Do you have hospital or operating room privileges? **If "Yes", where?**	◯	◯
9. Are you fluent in a language other than English? **If "Yes", please identify:**	◯	◯
10. Do you volunteer your services or expertise with any organization(s) in your community or abroad?If "Yes", please list:	◯	◯

Please list any professional affiliations:

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Section C: Dental School Information

Dental School:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		
Years practicing dentistry:		

Section D: Other Educational Experience

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

Education Type: ☐ Pre-Doctoral ☐ Post-Doctoral ☐ Other: (Specify:)

Institution:		
Address:		
City:	State:	Zip:
Graduation Date:	Degree Earned:	
Awards | Fellowships | Certificates Earned:		

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Section E: Practice Site Confirmation

Please provide information on the location(s) where you will be working if selected to participate in the program.

Total # of practice sites:_____ For all practice sites combined, **Total Annual Salary:** _____

Primary Practice:	Phone:
Start Date at Practice:	
# Clinical Hours Treating Patients Per Week:	
# Administrative Hours Per Week:	
Annual Salary | Compensation:	
Estimate your **CURRENT (**not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	**State:**	**Zip:**	**County:**

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Public Health Clinic:	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	○	○
Compensation for ALL practice sites:		

Secondary Practice:	Phone:
Start Date at Practice:	
# Hours/Week Treat Patients:	
Annual Salary | Compensation:	
Estimate your CURRENT (Not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	State:	Zip:	County:

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Public Health Clinic:	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	○	○

Tertiary Practice:	Phone:
Start Date at Practice:	
# Hours/Week Treat Patients:	
Annual Salary | Compensation:	
Estimate your CURRENT (Not anticipated) Maryland Medical Assistance Program (MMAP) recipient caseload percent (estimate %)	

Practice Address:

City:	State:	Zip:	County:

Practice Type:	Yes	No
Group Private Practice: If "Yes", please have the owner(s)/employer(s) complete and return the Letter of Understanding.	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Public Health Clinic:	○	○
If "Yes", Is/Are the owner(s) willing to support you in this endeavor?	○	○
Individual (solo) Private Practice: If "Yes", please provide a copy of the most recent business tax return.	○	○

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Section F: Employment History

Please list only relevant positions in reverse chronological order to coincide with current practice sites up to ten years.

Employer | Organization:			Phone:
Address:			
City:	State:	Zip:	
Position:	Period of Service	From:	To:
Reason for Leaving:			
Employer | Organization:			Phone:
Address:			
City:	State:	Zip:	
Position:	Period of Service	From:	To:
Reason for Leaving:			
Employer | Organization:			Phone:
Address:			
City:	State:	Zip:	
Position:	Period of Service	From:	To:
Reason for Leaving:			
Employer | Organization:			Phone:
Address:			
City:	State:	Zip:	
Position:	Period of Service	From:	To:
Reason for Leaving:			
Employer | Organization:			Phone:
Address:			
City:	State:	Zip:	
Position:	Period of Service	From:	To:
Reason for Leaving:			

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Section G: Educational Assistance History

	Yes	No
1. How did you hear about the Maryland Dent-Care Loan Assistance Repayment Program?		
2. Have you previously been awarded any other loan repayment? If "Yes", please name the program and describe the service agreement, including length of service and total $ amount of award.	◯	◯
	Yes	**No**
3. Have you ever applied to the Maryland Dent-Care Loan Assistance Repayment Program? If "Yes", what year(s)?	◯	◯
4. Have you ever been offered an award from the Maryland Dent-Care Loan Assistance Repayment Program and declined acceptance? If "Yes", what year(s)?	◯	◯
5. Are you currently obligated to any other agency for loan repayment or scholarships? If "Yes", please describe:	◯	◯
	Yes	**No**
6. Have you EVER breached any service obligation(s), contract(s), etc.?*	◯	◯
7. Have you EVER defaulted on an educational loan?*	◯	◯
8. Are you CURRENTLY in default on an educational loan?*	◯	◯

*If you responded yes to questions 6, 7, or 8 you are not eligible to apply for MDC-LARP.

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Section H: Personal Statement

The personal statement represents a significant portion of the candidate's application score.

Please use this section **ONLY** to provide an essay that briefly explains the following: (Only statements meeting specifications will be evaluated) Personal statement must not exceed provided space below.

1. Why you are applying to the MDC-LARP?
2. How your professional goals relate to the needs for the MDC-LARP?
3. Please describe in detail the professional/unique skills and knowledge you will bring to the MDC-LARP.

THE ABOVE TOPICS MUST BE ADDRESSED IN YOUR PERSONAL STATEMENT FOR CONSIDERATION

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Section I: Essay

The MDC-LARP application essay represents a significant portion of the candidates application score.

Please use this section **ONLY** to provide an essay on the following topic. Essay must not exceed provided space below.

Describe your plan for sustaining and increasing your MMAP population beyond the three year service term.