

# Mental Health and Addiction Services Development Board Loan Repayment Assistance Application Packet

**Eligible Applicants:**

Psychiatrists

Psychologists

Psychiatric nurses

Psychiatric Nurse Practitioners

Addiction counselors

Mental health professional (Licensed or licensure track)

Current Indiana Residents or Prospective Indiana Resident



***Division of Mental Health and Addiction***

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**Indiana Mental Health and Addiction Services Development Board**  
**APPLICATION PACKET**  
**Loan Repayment Assistance Program**  
**For Mental Health and Addiction Professionals**  
**Authorized by HEA 1360**

Please Note:

An application packet will not be considered complete unless the following documents are submitted:

1. **Application.**
2. **\*Proof of employment:** Complete the top portion of the *Employment Verification* form and have your employer complete the lower portion of the form or employment plan.
3. **\*Proof of Loans:** Submit a National Student Loan Data Systems (NSLDS) ([www.NSLDS.ed.gov](http://www.NSLDS.ed.gov)) statement as well as a Loan Verification Release Form for *each lender/servicer* who administers or holds any of your student loans. The NSLDS statement must contain all of the required loan information as outlined on the Loan Verification Release Form.
4. **\*Proof of financial information:** You must submit a copy of the most recent Federal Form 1040 you have filed. Your financial information will be kept confidential.
5. **Service Agreement:** Complete and sign the Loan Repayment Program Service Agreement.
6. **Personal Statement:** Submit a personal statement highlighting public service and a commitment to continued public service.
7. **\*Letter of Recommendation:** Submit a letter of recommendation from your current employer, to include their belief of your commitment to stay employed there for a minimum of one year.
8. **\*Transcripts:** Submit school transcripts.
9. **\*Resume:** Submit a copy of your current resume including your employment and education history as well as any notable professional affiliations or achievements.

*\* Indicates this section requires document(s) to be uploaded prior to final submission of the application.*

**Indiana Mental Health and Addiction Services Development Board**  
**Loan Repayment Assistance Program**  
**For Mental Health and Addiction Professionals**  
**OVERVIEW AND TERMS OF AGREEMENT**

The Indiana FSSA, Division of Mental Health and Addiction (DMHA), is the designated state agency to administer the Mental Health and Addiction Services Loan Repayment Assistance Program for the State of Indiana. This program provides repayment assistance of eligible educational loans for full-time psychiatrists, psychologists, addiction counselors and mental health professionals, who are licensed or on a licensure track. The intent of this program is to expand the workforce within the specified practice areas by encouraging the recruitment and retention of mental health and addiction professionals who will establish practices or accept positions within the State of Indiana.

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<b>TERMS OF SERVICE AGREEMENT</b>
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In consideration of the student loan repayment assistance for which I have been offered, under HB 1360, I hereby agree to the following:

**Employment:**

1. I will remain employed full time (30 hours per week minimum) in my specified mental health and/or addiction position for a period of service not less than twelve (12) months. I will notify DMHA, by email and within 48 hours, of any transfer to a new position or of my intention to voluntarily separate, resign, or retire from my position. In the event that I involuntarily leave my position or if I am involuntarily separated before completing the agreed upon period of service, I will be indebted to the Mental Health and Addiction Services Loan Repayment Assistance Program and must reimburse DMHA for the full amount of any student loan repayments made on my behalf under this service agreement. I further acknowledge that a sum equal to the amount that I am required to repay is recoverable by law.
2. Periods of leave without pay, or other periods during which I am not in pay status, does not count toward the required service period, and the service completion date must be extended by the total time spent in non-pay status. Absence due to uniformed service in a recognized branch of the United State military, authorized maternity/paternity leave, FMLA or due to compensable injury, however, is considered creditable within the sole discretion of the Mental Health and Addictions Development Programs Board.

**Eligibility:**

3. I must be in good standing for repayment for any federal student loans.
4. I must be licensed to practice psychiatry, psychology addictions or mental health counseling or be on licensure track to obtain licensure.
5. I must be either a new college graduate accepting a position or a new Indiana resident establishing a practice in Indiana in the field areas listed above.

**Loan Management:**

6. The Mental Health and Addiction Services Loan Repayment Assistance Selection Committee and DMHA as the disbursement agency is not responsible for the management of my loans or for fees assessed to my educational loans and will not negotiate with lenders how payments are to be applied. Loan Repayment Assistance made on my behalf does not exempt me from responsibility and/or liability for the full amount of any loan in which I am the debtor.
7. The State of Indiana will pay my lender a one-time payment directly based on the information I provided. As individual lenders may have different processes as to how the payment gets applied it is my responsibility to discuss the terms with the lender or note holder when applicable.
8. I authorize DMHA to verify the status, payment history, and outstanding balance of each qualifying loan, and to discuss the terms with the lender or not holder when applicable.
9. I will be required to submit to DMHA an employment verification form every six (6) months. If it is determined that I am out of compliance with program requirements, the Mental Health and Addiction Service Development Programs Board will review the information to determine a course of action.

**Tax Information:**

10. I understand that if awarded loan forgiveness benefits, I will be required to complete, sign and return a *Vendor Information Form* as the State Auditor will need this information to prepare a 1099 reporting form for this taxable income.
11. Any loan repayments made on my behalf may be taxable and subject to withholding. I am responsible for any income tax obligation resulting from the student loan repayment made on my behalf.

**Awardees' Responsibilities and Expectations:**

12. I must provide DMHA with any changes to my contact information (e.g. name change, mailing address, email, or telephone number) prior to the change occurring, if possible, or immediately after the change occurs.
13. The award of loan repayment assistance in any fiscal year does not guarantee future benefits, i.e., and awards are subject to the availability of appropriations.
14. Repayment benefits made on my behalf cannot exceed \$25,000 in any calendar year for more than four (4) years with the exception for addiction psychiatry, which is no more than five (5) years. This limitation should not, under any circumstances, be construed as an obligation of said benefits.

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Signature

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Date

## Section A: Applicant Information

Name: \_\_\_\_\_  
Last First MI

Position / Discipline:  Addiction Psychiatrist  
 Addiction Counselor  
 Psychiatrist  
 Psychologist  
 Psychiatric Nurse  
 Psychiatric Nurse Practitioner  
 Mental Health Counselor

Date of Hire: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Work Email Address: \_\_\_\_\_

Work Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

Are you employed full-time (A minimum of 30 hours/week/location)  Yes  No

Home Phone: \_\_\_\_\_

Personal Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

County: \_\_\_\_\_

### Licensure

In which state(s) are you licensed: \_\_\_\_\_

License number(s): \_\_\_\_\_

In what state are you currently practicing: \_\_\_\_\_

If not licensed, please explain your current efforts to obtain licensure: \_\_\_\_\_

Degree:

- **Doctorate - Credentialed**
- **Masters – Credentialed**
- **Masters – Not Credentialed, but on Licensure Track**
- **Bachelors – Credentialed**
- **Bachelors – Not Credentialed, but on Licensure Track**
- **Less than Bachelors**

Institution: \_\_\_\_\_

Year Obtained: \_\_\_\_\_

**Underserved Shortage Areas:**

Applicant employment location is in an underserved county/region with limited access to mental health and addiction professionals and/or related services according to recent data provided by the Health Resources and Services Administration (<http://muafind.hrsa.gov/index.aspx>)

**Section B: Educational Debt**

Please list all eligible loans and totals at the bottom of the page. The following loans are eligible for repayment:

1. A loan made, insured, or guaranteed under part B of subchapter IV of chapter 28 of Title 20 (Federal Family Education Loan Program);
2. A loan made under part C or D of subchapter IV of chapter 28 of Title 20 (William D. Ford Federal Direct Loan and Federal Perkins Loans);
3. A loan made under section 1078-3 or 1087e (g) of Title 20 (Federal consolidation loans and Federal Direct Consolidation loans, respectively).
4. \*Other educational loans may be considered and are subject to approval by the Mental Health and Addictions Services Development Programs Board.

The first listed loan will be the one that your benefits are paid to. If funds awarded are sufficient to completely pay the balance of the loan, the excess of the award will be paid to the second loan listed. You are required to disclose whether any of the loans listed below are financed through other educational loan repayment or forgiveness programs and/or grants.

Lender/Service	Outstanding Balance	Monthly Payment	Months Remaining	Other Source(s) of Loan Assistance

Total Original Loan Amount: \_\_\_\_\_

Total Outstanding Balance: \_\_\_\_\_

Total Monthly Payment: \_\_\_\_\_

Total Amount Paid Against Loan to Date: \_\_\_\_\_

Total Adjusted Annual Gross Income: \_\_\_\_\_ *(as stated on most recent 1040 filed)*



I verify that the information provided above is true and complete to the best of my knowledge and that the applicant meets the requirements established by the Indiana MENTAL HEALTH AND ADDICTION SERVICES DEVELOPMENT PROGRAM.

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Signature of Authorized Official

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Date

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Printed Name

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Title

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Email Address

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Telephone Number



## **Mental Health and Addiction Services Development Program**

**Section E: Personal Statement** *(A brief statement of 2,000 characters or less highlighting mental health and/or addiction experience and ongoing commitment to this field.)*