Montana State Loan Repayment Program (SLRP)
Site Application 2025-2026 Cycle

The Montana SLRP application requires the clinician's worksite to be a National Health Service Corps (NHSC) Active site or an approved Montana SLRP site. The site must meet the following criteria:

- Be in a Health Professional Shortage Area (HPSA); and
- Provide primary medical care, dental health, or mental health services; and
- See patients regardless of their ability to pay; and
- Be a public or non-profit site.

Federally Qualified Health Centers (FQHCs), Indian Health Service Facilities, Tribally Operated 638 Health Programs, Urban Indian Health Programs, and most correctional facilities qualify. Certified Rural Health Clinics (RHC), Critical Access Hospitals (CAH), Community Mental Health Centers (CMHC), State or Local Health Departments, Community Outpatient Facilities, Private Practices, School-based Clinics, Mobile Units, and Free Clinics are potential site types.

The HRSA Health Workforce Connector website can be used to verify if your site is an NHSC Active site. [Health Workforce Connector - Home Page (hrsa.gov)](https://hrsa.gov)

If your site is not an NHSC Active site, the site administrator must complete the Montana SLRP Site Application for consideration. For multiple site locations, a separate application must be submitted for each location. This Montana SLRP Site application, once approved, is valid for one (1) year.

The Montana SLRP follows the NHSC site requirements. https://nhsc.hrsa.gov/sites/eligibility-requirements

Site Application

1. **Name of Practice Site**: List the current practice name and include former/alternate names if applicable. If there are multiple site locations, each individual site must have its own application. The Site Point of Contact will be the first point of contact for all communications from the Montana Primary Care Office. This person is typically the site administrator, human resources officer, or business manager.

   Practice Name: _____

   Street Address: _____

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

   Website: _____ Phone Number: _____

   Parent Organization Name (if applicable): _____

Site Point of Contact: _____ Title: _____

Site Contact Email: _____ Phone Number: _____

2. **Practice Site Services:** Indicate which services your site provides.

Primary Medical Care _____   Pharmacy _____
Behavioral Health Care _____   Substance Use Disorder Care _____
Dental Health Care _____   Obstetrical/Maternal Health Care _____

3. **HPSA Scores:** Enter the Health Professional Shortage Area (HPSA) scores for your site. You can locate your HPSA scores here: https://data.hrsa.gov/tools/shortage-area/by-address.

Primary Medical Care HPSA _____

Mental Health Care HPSA _____

Dental Health Care HPSA _____

4. **Type of Organization**: Please complete each section for the practice site.

a. Private _____   Public _____

b. For Profit _____   Non-Profit _____

c. Site sub-type:
   • Federal Qualified Health Center (FQHC/CHC) _____
   • Certified Rural Health Clinic _____
   • Primary Care/ Family Practice Clinic _____
   • Mental Health Clinic/ Facility _____
   • Dental Health Clinic _____
   • American Indian Health Facility _____
   • Critical Access Hospital (CAH) _____
   • School Based Clinic/Program _____
   • Community Outpatient Facility _____
   • Correctional or Detention Facility _____
   • Private Practice _____
   • Other, specify _____

5. **Sliding Fee Scale Assurances:** Complete the sliding fee schedule assurances.

a. Does your site provide discounts via a sliding fee schedule for individuals with annual incomes at or below 100% of the [HHS Poverty Guidelines](#)?
- Yes _____ No _____

b. Are these discounts for services at no charge, or at a nominal charge?
- Yes _____ No _____

c. Does your site provide a schedule of discounts for individuals with annual incomes between 100% and 200% of the HHS Poverty Guidelines?
- Yes _____ No _____

d. Is eligibility for your sliding fee scale based only on family size and income?
- Yes _____ No _____

e. Does your fee policy exclude other factors such as requiring proof of assets, insurance eligibility letters, insurance applications, or population type to assess whether people are eligible?
- Yes _____ No _____

f. Does your site accept Medicare, Medicaid, and CHIP and make every reasonable effort to secure payment, in accordance with the schedule of fees or discounts, from the patient and/or third party?
- Yes _____ No _____

g. Does your site have posted signage displayed in the office common area and on your website that states no one will be denied services due to the inability to pay, and is there a discounted/sliding fee schedule available based on family size and income?
- Yes _____ No _____

6. **Patient Demographics:** Complete the patient demographic information for the time frame covering the previous six (6) months, if known.

a. Percentage of patients provided Outpatient services: _____
b. Percentage of patients provided Inpatient services: _____
c. Percentage of patients on a sliding fee schedule: _____
d. Percentage of Medicaid patients: _____
e. Percentage of Medicare patients: _____
f. Percentage of CHIP patients: _____
g. Percentage of patients identifying as homeless: _____
h. Percentage of patients identifying as American Indian/Alaskan Native: _____
i. Percentage of patients identifying as migrant farmworker: _____
j. Total number of unduplicated patient encounters in the past six months: _____

7. **Attachments:** Attach each of the listed documents to this application.

    a. Financial assistance policy: _____

    b. Sliding fee scale: _____

    c. Application for financial assistance: _____

    d. Photo of posted signage notifying patients of your sliding scale program: _____

    e. Copy of recruitment and retention plan: _____

    f. SUD sites must include documentation of the suite of services available: _____

    g. Behavioral Health sites must include documentation of access to ancillary, inpatient, and specialty care not provided on site (referral policy, MOU/MOAs, contracts, and/or agreements): _____

8. **Signatures:** The site administrator must sign the SLRP Site Application attestation.

By signing below, I attest that the information and documentation contained in this SLRP Site Application are true and accurate to the best of my knowledge.

Primary Site Contact: _____ Title: _____
Email address: _____ Phone Number: _____
Secondary Site Contact: _____ Title: _____
Email address: _____ Phone Number: _____

Primary Contact Signature: _____
Date: _____

Completed applications may be emailed to the Montana PCO at MontanaPCO@mt.gov.