Overview:
The Rural Dentist Program, in coordination with the Department of Health and Environmental Control’s Public Health Dentistry Program, is established at the Medical University of South Carolina. The funds appropriated to the Medical University of South Carolina for the Rural Dentist Program shall be administered by the South Carolina Area Health Education Consortium physician recruitment office. The Medical University of South Carolina is responsible for the fiscal management of funds to ensure that state policies and guidelines are adhered to.

To be eligible for the Dental Loan Repayment program, all applicants must have no outstanding service obligation for health professional service to the Federal Government (e.g., an active military obligation or National Health Service Corp), a State (e.g. State Loan Repayment Program or Scholarship Program obligation) or other entity, unless the obligation would be completed prior to receipt of the Dental Loan Repayment Award. All applicants must be a U.S. citizen (either U.S. born or naturalized), U.S. national or a Lawful Permanent Resident, and must provide documentation of their status. Acceptable documents include, as applicable, a U.S. birth certificate issued by a city, county, or state agency of the United States; the identification page of an unexpired U.S. passport; or a Certificate of Citizenship, a Naturalization Certificate or a Green Card. A Lawful Permanent Resident is also known as a "Permanent Resident Alien," "Resident Alien Permit Holder," or "Green Card Holder." Please note that a state driver's license or state-issued non-driver's identification, Residence Card, Nursing License, or Social Security Card are not acceptable proof of U.S. citizenship or status as a U.S. national.

Board:
While this program is administered by South Carolina AHEC, a Board is created to manage and allocate these funds to insure the location of licensed dentists in rural areas of South Carolina and on the faculty of the College of Dental Medicine at MUSC. The Board will be composed of the following: The Dean, or his Designee, of the MUSC College of Dental Medicine; three members from the South Carolina Dental Education Foundation Board who represent rural areas; and the President, or his designee, of the South Carolina Dental Association. The Director of DHEC’s Office of Primary Care; the Director or his designee of the Department of Health and Human Services; and the Executive Director of the South Carolina Dental Association shall serve as ex-officio members without vote.

Priority:
The intent of this program is to assist dentists in repaying educational loans in order that they may practice in a Health Professional Shortage Area (HPSA) in South Carolina or serve as full-time faculty at the MUSC College of Dental Medicine, without the financial burden of unpaid educational loans. The Board expects that during the commitment period, the dentists will either establish viable practices and become involved in their communities so that they will continue practicing in the area after the funding period is over, or will establish viable academic careers at the College of Dental Medicine. Priority for this program will be given to those demonstrating need and expressing honest intent to remain in the underserved area once funding is completed or are in an area of critical need at the College of Dental Medicine.
Application Process:
Applications will be accepted at any time. Interested persons must apply by February 15, 2020 for consideration for the next funding cycle that begins July 1, 2020. Applicants must identify the community in South Carolina in which they wish to practice or are currently practicing. Applications will also be accepted from dentists who wish to serve on the faculty at the MUSC College of Dental Medicine.

The following documentation must be submitted with the application: a curriculum vitae, copies of all educational loan documents, and your most recent income tax return with your social security number redacted. To qualify for this program, loans must be made with a recognized financial institution.

Applications from providers currently in practice must include an individual Medicaid provider number in order to be considered. This stipulation does not apply to students who have not yet completed their training who will need to obtain an individual Medicaid provider number to be eligible for loan repayment.

Contract:
Accepted dentists will sign a contract with South Carolina AHEC and MUSC to practice in an underserved area or teach at the MUSC College of Dental Medicine, for a designated amount of time. The terms of the contract stipulate that all participants will be expected to treat at least 100 unduplicated Medicaid patients in South Carolina. For students who will establish practice upon completion of training, to become a Medicaid provider, access the South Carolina Department of Health and Human Services’ (DHHS) website at https://www.scdhhs.gov/. The South Carolina Dental Association (SCDA) can assist with obtaining a Medicaid provider number.

Payment:
Loan reimbursement payments are made annually to the loan institution.

Penalty for Default:
If the dentist fails to execute the full terms of the contract, the Rural Dentist Program Board will determine the appropriate disposition. The penalty may be up to a triple repayment of all money received plus interest at the prime rate plus 10% as of the day of default (plus any legal fees and costs necessary to collect the money). In the case of pregnancy, extended leave during which the dentist does not serve as a full time dentist or special circumstances, a period of time equal to the extended leave shall be added to the contract period.

Contact Information:
Kristin C. Cochran, MHA
Director of Recruitment and Retention Programs
South Carolina Area Health Education Consortium
Charleston, SC 29425
(p) 843-792-6977    (f) 843-792-4430
cochrak@musc.edu
http://www.scahec.net/professionals.html

Revised August 2019
Faculty Application for the South Carolina AHEC Rural Dentist Program

INSTRUCTIONS: Complete this application to receive consideration for the Rural Dentist Program. The following documentation must be submitted with the application: a curriculum vitae, copies of all educational loan documents, and your 1040 Form from your most recent tax return with your social security number redacted. To qualify for this program, loans must be made with a recognized financial institution.

To be eligible for the Dental Loan Repayment program, all applicants must have no outstanding service obligation for health professional service to the Federal Government (e.g., an active military obligation or National Health Service Corp), a State (e.g., State Loan Repayment Program or Scholarship Program obligation) or other entity, unless the obligation would be completed prior to receipt of the Dental Loan Repayment Award.

An email will be sent to each applicant confirming the application packet is complete. If an email isn’t received within three business days, please email the South Carolina AHEC office at cochrak@musc.edu to confirm receipt.

I. Personal Information

1. Name
   ___________________________________________    ___________________________    _____
   Last                         First          MI

2. Address
   ____________________________________________

   ____________________________________________
   City                                            State               Zip

3. Telephone
   ________________________   _____________________   __________________
   Work Phone                                Home Phone                      Cell Phone

4. Email Address
   ____________________________________________

5. Are you a U.S. citizen?  Yes_________  No_________

6. Are you a SC Resident?  Yes_______  No_______

7. Are you an underrepresented minority?  Yes_____  No______
   Please indicate race/ethnicity:  African American____; Native American____; Hispanic____

8. Total Educational Indebtedness ____________________________

9. Have you previously applied for funding through the South Carolina Rural Dentist Program? ______

II. Professional Background

1. Dental School Institution
   ____________________________________________

2. Residency Program
   Yes____ No____ Specialty ___________________ Date Graduated________

3. Current Position
   Practicing Dentist_____; Resident_____; Student____;

4. Dental License Number: __________________________

5. Medicaid Provider Number: __________________________

6. Name of Department and Division at MUSC College of Dental Medicine: __________________________

7. Total number of years as full-time faculty at MUSC College of Dental Medicine: ____________________

8. Total number of years as part-time faculty at MUSC College of Dental Medicine: ____________________

9. Faculty rank at MUSC College of Dental Medicine: __________________________
III. Service Obligation Information

1. Did you incur a service obligation with any state, government, or other entity while obtaining your dental degree?
   Yes ___ No ___ If yes, please describe the type of obligation, including the starting and ending dates.
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

2. Have you received, applied, or plan to apply for additional funding through any state, government, or other entity?  (Yes/No) ______
   If yes, please provide the source, amount and duration of these funds.
   ______________________________________________________________________________________
   ______________________________________________________________________________________
   ______________________________________________________________________________________

IV. Practice Information

Please indicate your practice location(s).  IF YOU PRACTICE IN MORE THAN ONE LOCATION, PLEASE INDICATE NUMBER OF HOURS AT EACH LOCATION.

1. Primary Practice Location
   ____________________________________________________________    _____________________    _________    ________
   Name of Practice                                                Street Address of Practice                          City       State       Zip

2. Practice County___________________________

3. How many hours per week do you expect to serve at this location? ________________

Secondary Practice Location Information (If Applicable)

4. Secondary Practice Location
   ____________________________________________________________    _____________________    _________    ________
   Name of Practice                                                Street Address of Practice                          City       State       Zip

5. Practice County___________________________

6. How many hours per week do you expect to serve at this location? ________________

Please indicate the following:

7. Practice Type:
   Solo Practice_______ Group Practice_______ College of Dental Medicine _____ Other_________
V. Applicant Background Information

Date and Place of Birth ________________________ Permanent Home of Record ____________________  

(Prior to college)

College or University Attended ___________________________ ____________________________  

__________________________________________________________   __________________________

Signature                                                                              Date

PLEASE NOTE: IT IS YOUR RESPONSIBILITY TO MAKE SURE THIS IS A COMPLETE APPLICATION. INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.

Revised 3/18