The Legislature of South Carolina provides that the Medical University of South Carolina is the state agency responsible for administering the South Carolina Area Health Education Consortium (South Carolina AHEC) program. A high priority of South Carolina AHEC is the recruitment and placement of health care providers. The state legislature has provided funds to South Carolina AHEC to assist in the recruitment and placement of primary care physicians in designated underserved areas of South Carolina.

Overview:
The State Incentive Grant program provides funding to primary care physicians (Family Practice, Internal Medicine, Pediatrics, and Ob/Gyn) who contract for a period of four years to practice in rural or underserved areas of South Carolina. General surgeons and psychiatrists practicing at independent, small, rural hospitals are also eligible to apply. The amount of the award will vary with the minimum award being $60,000 and the maximum award being $100,000 depending upon the type of practice setting and the population of the county. All recipients must be licensed by the State of South Carolina and board certified. Applications are encouraged from residents who will be completing their training within the year, and it is expected that the resident will become board certified at their earliest opportunity in accordance with the requirements of their specialty.

To be eligible for the State Incentive Grant program, all applicants must be U.S. citizens and are not eligible for consideration if they have previously received an award from the Rural Physician Incentive Grant Program or the Rural Physician Loan Repayment Program. Providers must also have practiced in the community for less than five years to be eligible for the program.

The Rural Physician Board recognizes the need for advanced practice professionals in underserved areas of South Carolina as well. The Rural Physician Board will accept applications from credentialed Nurse Practitioners, Nurse Midwives, and Physician Assistants who contract for a period of four years to practice in a rural or underserved area of South Carolina. The amount of the award will vary with the minimum award being $30,000 and the maximum award being $50,000 depending upon the type of practice setting and the population of the county. The Rural Physician Board gives priority to physicians and the number of awards for advanced practice professionals may vary from year to year based on the demand for limited funds.

Board:
The program is administered by South Carolina AHEC and managed by the Rural Physician Board, the members of which are defined in the South Carolina Code of Laws. This board meets periodically to vote on applicants and to discuss other items of business. The Rural Physician Board is composed of representatives from the South Carolina Primary Health Care Association, the South Carolina Medical Association, the South Carolina Commission on Higher Education, the South Carolina DHEC, the South Carolina Hospital Association, the South Carolina Department of Health and Human Services, the USC School of Medicine, an appointee of the South Carolina House of Representatives Medical, Military, Public and Municipal Affairs Committee, an appointee of the South Carolina Senate Medical Affairs Committee, and three at-large members with two representing nursing and one representing allied health sciences.

Application Process:
**For the funding period of July 1, 2017, through June 30, 2018:** Applications will be accepted August 15, 2016, until March 15, 2017, and considered by the Rural Physician Board shortly thereafter. Providers whose applications are approved will be notified in June and awarded contracts effective July 1, 2017. Letters will be mailed to all applicants indicating if they were approved or not approved.
Priority:
The intent of this program is to assist physicians and advanced practice professionals in establishing or joining practices in rural or underserved areas. Ideally, during the four year period of commitment, they will develop viable practices and become involved in their communities, so that they will continue practicing in the area after the funding period is over. 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. Candidates are prioritized using an objective checklist that awards points in the following categories: South Carolina Medical, Nursing, or PA School, South Carolina Residency Program, Completion of a Rural Residency Training Track, Community Need, Committee Recommendation, Specialty, Previous Applicant and Underrepresented Minority.

Contract:
Accepted providers will sign a contract with South Carolina AHEC and MUSC to practice medicine in an underserved area for a designated amount of time. The terms of the contract stipulate that all providers will accept both Medicare and Medicaid patients and their practice not discriminate against any person on the basis of their ability to pay. Continuation of the contracts from year to year is contingent upon the availability of funds allocated by the South Carolina General Assembly and a contract from the South Carolina Department of Health and Human Services. Accepted providers are expected to maintain an outpatient primary care practice at the designated location.

Payment:
Payment schedules will be determined by the total amount of award and will be included in the contracts. Payments are made annually at the end of the contract year. If the practitioner leaves the employment of the practice during the contract year, the practitioner will be considered to have terminated the contract and will not receive the annual payment.

Contact Information:
Kristin C. Cochran, MHA
Director of Recruitment and Student Programs
South Carolina Area Health Education Consortium
Medical University of South Carolina
19 Hagood Avenue
MSC 814, Suite 802
Charleston, SC 29425
(p) 843-792-6977    (f) 843-792-4430
cochrak@musc.edu
http://www.scahec.net/incentivegrant.html
INSTRUCTIONS: Complete this application to receive consideration for the South Carolina AHEC State Incentive Grant. Please attach Curriculum Vitae and Practice Site Profile (Required).
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.

Application Part 1

I. Personal Information

1. Name
   ____________________________    ___________________________    _____
   Last          First             MI

2. Current Home Address
   _____________________________________________________________________
   Address
   _____________________________________________________________________
   City  State                            Zip

3. Home Telephone
   _________________________________
   (With Area Code)

4. Current Work Address
   ________________________________________________________________
   Business Name
   _____________________________________________________________________
   Address
   _____________________________________________________________________
   City  State                            Zip

5. Work Telephone
   _________________________________
   (With Area Code)

6. Email Address
   _________________________________

7. Are you a U.S. citizen? (Yes/No) _________

8. Are you a SC resident? (Yes/No) _________

9. Are you Hispanic/Latino? (Yes/No) _________

10. Race (Please check all that apply)
    American Indian/Alaska Native
    Asian
    Black
    Native Hawaiian or Other Pacific Islander
    White

11. Total Educational Indebtedness $________________________

12. Have you previously applied for funding through the South Carolina Rural Physician Program (Incentive Grant or Loan Repayment)? (Yes/No) _________ Were you funded? (Yes/No) _________
II. Professional Background

1. Medical School/Health Professions Program _________________________________________________________________

Date of Graduation (Month/Year) ______________________

Is the health professions program an online program? (Yes/No) __________
If yes, please indicate the state where the majority of clinical training was completed. ____________________________

2. Clinical Specialty

Family Practice □
Internal Medicine □
Internal Medicine/Pediatrics □
Ob/Gyn □
Pediatrics □
General Surgery □
Psychiatry □
Other □ If other, please list. _________________________

3. Practitioner Type

Nurse Midwife □
Nurse Practitioner □
Physician □
Physician Assistant □

4. Current Training Status

Advanced Practice Student □
Resident □
Fellow □
Training Complete □

5. Most Recent Residency Program/Fellowship Completed _______________________________________________________

_________________________________________________________    _____________________    _________    ___________

Primary Street Address of Program

6. Date you will complete/completed residency program (Month/Year) ______________________

7. Have you completed a Rural Residency Training Track? (Yes/No) __________

8. Additional Residency/Fellowship Training _______________________________________________________

_________________________________________________________    _____________________    _________    ___________

Primary Street Address of Program

9. Date you completed additional residency/fellowship training (Month/Year) ______________________

10. Are you Board/Professionally Certified? (Yes/No) __________

What Clinical Area(s)? _____________________________ Date of Certification _______________ Month/Year

11. If you are not Board Certified, do you expect to receive board certification within a year? (Yes/No) __________

12. South Carolina Licensing Agency_____________________ South Carolina License Number ____________________
III. Other Sources of Funding

1. Did you incur a service obligation with any state, government, or other entity while obtaining your medical/health professions degree? (Yes/No) _______

If yes, please describe the type of obligation, including the starting and ending dates.
___________________________________________________________________________________________________
___________________________________________________________________________________________________

2. Have you received or will you be receiving any other loan repayment or practice incentives from state, federal or private sources? (Yes/No) _______

If yes, please provide the source, amount and duration of these funds.
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

IV. Incentive Grant Practice Location(s)

Please indicate your intended practice location(s) for purposes of incentive grant funding.

Primary Practice Location Information

1. Primary Practice Location

___________________________________________________________________________________________________

Name of Practice
_______________________________________________________    _____________________    _________    ________
Street Address of Practice                                                                             City                               State                   Zip

2. Practice County_________________________

3. Practice Type (Please check one)     Community Health Center □
                                          Federally Qualified Health Center □
                                          Group Practice □
                                          Rural Health Center □
                                          Solo Practice □
                                          Other □  If other, please list. _________________________

4. How many hours per week do you expect to serve at this location?  _________________________

5. How long have you been in clinical practice at the above location? __________________________

6. If not yet in practice at the above location, when will you begin clinical practice at this location?  ______________

Secondary Practice Location Information (If Applicable)

7. Secondary Practice Location

___________________________________________________________________________________________________

Name of Practice
_______________________________________________________    _____________________    _________    ________
Street Address of Practice                                                                             City                               State                   Zip
8. Practice County_________________________

9. Practice Type (Please check one)  
   Community Health Center □  
   Federally Qualified Health Center □  
   Group Practice □  
   Rural Health Center □  
   Solo Practice □  
   Other □ If other, please list. _________________________

10. How many hours per week do you expect to serve at this location? _________________________

11. How long have you been in clinical practice at the above location? ______________

12. If not yet in practice at the above location, when will you begin clinical practice at this location? ______________

V. Applicant Background Information

1. Date of Birth ___________________

2. Place of Birth ___________________________       _______________________
   City                                                            State

3. Home Prior to College ___________________________       _______________________
   City                                                            State

4. High School at Time of Graduation ___________________________       _______________________
   City                                                            State
   Name

5. College or University at Time of Graduation ___________________________       _______________________
   City                                                            State
   Name

6. Spouse/Partner’s Place of Birth ___________________________       _______________________
   City                                                            State

7. Spouse/Partner’s Home Prior to College ___________________________       _______________________
   City                                                            State

8. Spouse/Partner’s College or University at Time of Graduation ___________________________       _______________________
   City                                                            State
   Name

9. Do you or your spouse/partner have relatives currently practicing primary care medicine in rural South Carolina?  
   (Yes/No) ___________

   If yes, please provide the county/counties? ___________________________       _______________________

10. Have you ever served as a preceptor for health professions students? (Yes/No) ___________

   If yes, please provide the disciplines.______________________________
I understand that application to this program indicates a desire to commit to practice in an underserved area of South Carolina for a period of time contingent upon amount of support I receive.

______________________________________________________   __________________________
Name                                                                                                              Date

Please describe any professional experiences during your health professions training program, medical school or residency training that were associated with rural areas or underserved populations (include any experiences sponsored by a state AHEC program). Please note the location, population served and the length of each activity.

Please submit the completed application, curriculum vitae, and practice site profile to Kristin Cochran at cochrak@musc.edu or fax to 843-792-4430.
South Carolina Rural Physician Incentive Grant Program

Application Part 2: Practice Site Profile

Name of Applicant _____________________________

Section I:

1. Name of Practice: __________________________________________________

2. Practice Address: __________________________________________________

3. Practice Site Contact Person: _________________________________________

4. Contact Person Phone Number: ________________________________________

5. Contact Person Fax Number: __________________________________________

6. Contact Person E-Mail Address: _______________________________________

Section II:

1. List Current FTE count for the following:

   Family Practitioners _______   General Surgeons _______
   Internists _______           Med/Peds _______
   Ob/Gyns _______             Pediatricians ______
   Psychiatrists______         Nurse Midwives _________
   Nurse Practitioners _________   Physician Assistants _______

2. List Desired FTE count for the following:

   Family Practitioners _______   General Surgeons _______
   Internists _______           Med/Peds _______
   Ob/Gyns _______             Pediatricians ______
   Psychiatrists______         Nurse Midwives _________
   Nurse Practitioners _________   Physician Assistants _______
3. List your practice’s referring hospital(s) and state the current medical staff status:


4. Report your approximate current patient mix using the following categories:

Private Insurance ________   Uninsured/Self Pay __________

Medicare ___________    Medicaid ____________

Other __________

Section III:

As conditions of participation in the South Carolina Rural Physician Incentive Grant Program, we the Practice agree to:

A. Accept assignment for individuals who are beneficiaries under Medicare.
B. Enter into an appropriate agreement with the South Carolina Department of Health and Human Services for individuals who are beneficiaries under the Medicaid program.
C. Make every effort to provide health care services to individuals who are unable to pay for care by discounting fees taking into consideration the individual’s income and family size.
D. Report to the South Carolina Area Health Education Consortium (AHEC) on an annual basis, the numbers of patients seen by the Practice under categories A-C above.

Signatures below are assurance that this document contains true and correct information and that the Practice agrees to comply with all of the conditions of participation, A-D, listed above.

Name of Site Official:  ____________________________________

Signature of Approving Official: ____________________________

Title: __________________________  Date: _______________________