



LOS ANGELES COUNTY DEPARTMENT OF MENTAL HEALTH
OFFICE OF ADMINISTRATIVE OPERATIONS



Mental Health Psychiatrist Student Loan Repayment Incentive Application

Please note incomplete applications and applications with falsified statements will be automatically disqualified.

The details of the Psychiatrist Student Loan Repayment Incentive are set forth in Title 6 of the Los Angeles County Code, Section 6.86.020.E.

I attest that all applies:

- I am an eligible Psychiatrist (Psychiatrist or Supervising Psychiatrist who is employed with the Department of Mental Health (DMH) on a full-time monthly permanent basis or Grandfathered Eligible Psychiatrist (an Eligible Psychiatrist who has completed at least one (1) continuous year of Qualifying Service as of February 15, 2018);
I have a Qualifying Student Loan (loan or portion of loan if consolidation taken and used for cost of post graduate or medical school education);
I have completed the period of Qualifying Service (active full-time on-the-job performance with DMH which includes approved leave of up to four (4) weeks in any one-year period; and
I have not participated or received funds from the DMH Psychiatrist Recruitment Incentive Program.

Date of Qualifying Service: From: \_\_\_\_\_ To: \_\_\_\_\_

Please check the year of the application:

New [ ] Year 2 [ ] Year 3 [ ] Year 4 [ ] Year 5 [ ] Change/Update [ ]

APPLICANT INFORMATION

Form fields for Applicant Information: First Name, Last Name, Social Security Number, Home Address, City, State, Zip Code, Personal Phone Number, Personal E-Mail, Race, Ethnicity, and a request for the Student Loan Repayment award payment of \$.

CURRENT EMPLOYMENT INFORMATION

Form fields for Current Employment Information: Job Title, Employee Number, Discipline, Agency/Program Name, Language Capability, Unit Code, Number of Hours Worked Per Week, Employment Start Date, Date of Performance Evaluation period, Work Address, City, State, Zip, Work Phone Number, Service Area, and Work E-Mail.

**ACADEMIC INFORMATION OF APPLICABLE QUALIFYING LOAN #1**

Academic Institution \_\_\_\_\_  M.D.  Ph.D.  
Degree(s) Completed \_\_\_\_\_ Date of Graduation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**ACADEMIC INFORMATION OF APPLICABLE QUALIFYING LOAN #2**

Academic Institution \_\_\_\_\_  M.D.  Ph.D.  
Degree(s) Completed \_\_\_\_\_ Date of Graduation \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Do you have additional academic information which is a part of your Qualifying Loan(s)?**  YES (Please complete the addendum form, page 4)  
 NO

**LENDER INFORMATION**

- List source(s) and amount(s) of outstanding Qualifying Student Loans used to finance your education.
- You must submit proof of debt for those loans obtained during the course of your post graduate or medical school education which led to your current license as a psychiatrist qualified for this program.
- If your loans have been consolidated, submit proof of consolidation.
- Please submit current student loan statements that include the name of the lender, payment address, balance owed, account number and monthly payment amounts. Online printouts are acceptable.

**QUALIFYING STUDENT LOAN #1**

Lending Institution \_\_\_\_\_ Name of Company/Institution you make your check payable to \_\_\_\_\_

Account Number \_\_\_\_\_ Monthly Payment \_\_\_\_\_ Current Outstanding Balance \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. Number \_\_\_\_\_

**QUALIFYING STUDENT LOAN #2**

Lending Institution \_\_\_\_\_ Name of Company/Institution you make your check payable to \_\_\_\_\_

Account Number \_\_\_\_\_ Monthly Payment \_\_\_\_\_ Current Outstanding Balance \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Tel. Number \_\_\_\_\_

**Do you have additional lender information which is a part of your Qualifying Loan(s)?**  YES (Please complete the addendum form, page 4)  
 NO

**DOCUMENTS: Please attach the following documents to complete your application:**

- Most Recent DMH Employment Performance Evaluation
- Most Recent Student Loan/Consolidated Statements
- Copy of current Driver's License to validate identification

**TERMS AND CONDITIONS**

I understand that, if chosen as an award recipient, I will receive a payment of up to \$50,000 annually (pre-tax), not to exceed the outstanding student loan owed, for up to five (5) times.

In addition, I agree to the following terms and conditions:

1. I must complete one year of continuous year of Qualifying Service or have completed one continuous year of Qualifying Service as of February 15, 2018;
2. I must have an existing unpaid Qualifying Student Loan;
3. I must have a departmental performance evaluation with an overall rating of "competent" or better for the most recent performance evaluation or that period; and
4. I am not receiving or received payments from the Mental Health Psychiatrist Recruitment Incentive Program pursuant to County Code Section 6.86.020.D.

For each additional year, Eligible Psychiatrists must continue to be eligible and satisfy all requirements as well as provide proper documentation of outstanding student loan amount.

**Incentive Program Details**

- Eligible Psychiatrists must have and be able to show proof of an outstanding student loan balance for post graduate and/or medical school education.
- If there are any reductions to the outstanding student loan amount, participants must notify DMH in writing of the new outstanding student loan balance. Such reductions may include debt forgiveness or other funds that are intended to be used as payment towards the student loan balance and will be deducted from the total outstanding amount and result in a new Qualifying Student Loan.
- Funds will be paid out as participants meet eligibility requirements.
- The total amount paid to any participant will not exceed the total amount owed to the loan institution(s).
- Payment will be made directly to the participant through payroll. All required payroll deductions will be applied prior to the payment being made, and participants will be responsible for any and all applicable taxes resulting from the payments they receive.
- The incentive amount paid is unrelated to retirement benefits and will not be considered "compensation earnable" for the purpose of determining retirement benefits.
- Upon receipt of each loan repayment, participant is required to submit proof verifying that all award amounts (after-tax) have been paid directly to the lender and used to only repay outstanding student loan.
- Any change in employment, inclusive of medical or maternity leave, must be reported to DMH/Office of Administrative Operations at [MDIncentive@dmh.lacounty.gov](mailto:MDIncentive@dmh.lacounty.gov).
- Payment to the financial institution(s) holding the student loan(s) is the responsibility of the participant.
- The program will continue as long as funding is available. The County is under no obligation to continue this program if funding ceases.

***By signing below, I acknowledge that I have read, understand, and agree to the provisions of the Mental Health Psychiatrist Student Loan Repayment Incentive as outlined in the attached Los Angeles County Ordinance (Los Angeles County Code Section 6.86.020.E) and attest under penalty and perjury that the information provided in this application is true and correct.***

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Employee Signature: \_\_\_\_\_

Employee Number: \_\_\_\_\_

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**ADDENDUM FORM**

**ACADEMIC INFORMATION OF APPLICABLE QUALIFYING LOAN #3**

_____	<input type="checkbox"/> M.D. <input type="checkbox"/> Ph.D.	_____
Academic Institution	Degree(s) Completed	Date of Graduation
_____	_____	_____
Address	City	State
_____	_____	_____
		Zip

**ACADEMIC INFORMATION OF APPLICABLE QUALIFYING LOAN #4**

_____	<input type="checkbox"/> M.D. <input type="checkbox"/> Ph.D.	_____
Academic Institution	Degree(s) Completed	Date of Graduation
_____	_____	_____
Address	City	State
_____	_____	_____
		Zip

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**QUALIFYING STUDENT LOAN #3**

_____	_____			
Lending Institution	Name of Company/Institution you make your check payable to			
_____	_____	_____		
Account Number	Monthly Payment	Current Outstanding Balance		
_____	_____	_____	_____	_____
Address	City	State	Zip	Tel. Number

**QUALIFYING STUDENT LOAN #4**

_____	_____			
Lending Institution	Name of Company/Institution you make your check payable to			
_____	_____	_____		
Account Number	Monthly Payment	Current Outstanding Balance		
_____	_____	_____	_____	_____
Address	City	State	Zip	Tel. Number

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**I TO BE COMPLETED BY OFFICE OF CLINICAL OPERATIONS**

*I certify that the employee named above is currently working on a full-time monthly permanent basis (as defined in Los Angeles County Code, section 6.28.020.B) which makes them eligible to participate in this program.*

**Program Manager/Designee:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Chief Deputy Director/Designee: \_\_\_\_\_ Date: \_\_\_\_\_

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**II TO BE COMPLETED BY OFFICE OF ADMINISTRATIVE OPERATIONS (OAO)**

Date of last performance evaluation: \_\_\_\_\_

Did the employee receive an overall rating of "Meets" or "Exceeds" on his or her last performance evaluation?

Yes  No

Total Student Loan Balance Amount: \_\_\_\_\_ Date: \_\_\_\_\_

Approved:  Denied:

OAO Program Analyst/Manager Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Request Forwarded to Human Resources by: \_\_\_\_\_ Date: \_\_\_\_\_

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**III TO BE COMPLETED BY HUMAN RESOURCES (HR)**

Has the employee completed 1,040 service hours for the qualifying year of \_\_\_\_\_? Yes  No

If no, was there a break in service? Yes  No  Dates: \_\_\_\_\_

Comments: \_\_\_\_\_

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Verified by HR Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Net Amount: \_\_\_\_\_ Date Check Issued: \_\_\_\_\_ Date Request Processed: \_\_\_\_\_

**\*Return signed application to OAO staff within 2 weeks of processing\***

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For information regarding this application or the Psychiatrist Student Loan Repayment Incentive Program, please contact the Office of Administrative Operations at <a href="mailto:MDIncentive@dmh.lacounty.gov">MDIncentive@dmh.lacounty.gov</a>
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