North Carolina Licensed Workforce Loan Repayment Program – MH, SU, IDD & TBI: Employment Verification

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Mental Health, Developmental Disabilities and Substance Use Services

Applicant Agency Contact Information (Attestant, must be one level above the applicant)

Name of Agency: _____

Attestant First Name: _____ Attestant Last Name: _____

Attestant Work Email: _____ Attestant Work Phone: _____

Attestant Agency Address: _____

Questions

Please provide the applicant's most recent official date of hire as it appears in their employment record.

Date of Hire (dd/mm/yyyy): _____

Name of Applicant: _____

Please provide the current classification of the applicant as it appears in their employment record.

The applicant is classified as ☐ Full-Time (32hr/wk) ☐ Part-Time

Their duration of employment is ☐ Permanent ☐ Temporary

Average hours worked per week _____

To be completed after the applicant is approved for the program. Please confirm the dates during which this employee was actively employed with your agency. These dates (dd/mm/yyyy) should match the reporting period provided by the participant.

From: _____ **To:** _____

Does the agency where the applicant is employed meet the rural or underserved designation? Check at https://www.ruralhealthinfo.org/am-i-rural#/.

☐ Yes ☐ No

This site provides services to a population in which at least 40% of individuals are enrolled in Medicaid or lack adequate health insurance coverage, including those who are uninsured or underinsured.

☐ Yes ☐ No

Attestant Signature

By submitting your name, title, and signature you are attesting to the accuracy of the information in this application. I certify that my answers are true and complete to the best of my knowledge. If this application results in a loan payment award, I understand that false or misleading information in the verification may result in the applicant's release from the loan repayment program and penalties to any/all signed.

Attestant Signature: _____

Attestant Name: _____

Attestant Title: _____

Date (dd/mm/yyyy): _____

DHHS USE ONLY

Loan Repayment Specialist Approved: ☐ Yes ☐ No

Signature: _____ Date: _____

Contract Administrator Approved: ☐ Yes ☐ No

Signature: _____ Date: _____