



# State of Wisconsin Higher Educational Aids Board

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John Reinemann  
Executive Secretary

## PRIMARY CARE AND PSYCHIATRY SHORTAGE GRANT Claim for Financial Assistance

**Who may apply for a claim for financial assistance:** Individuals who have a valid Notice of Intent to Practice in an Underserved Area on file with the Higher Educational Aids Board (HEAB), who have completed a graduate medical training (GMT) program in the state of Wisconsin in a qualifying specialty or sub-specialty, and who have practiced in a qualifying underserved area in the state of Wisconsin for at least one year after completing the GMT program may submit a claim for financial assistance.

**Applicants:** Please complete sections A, B, C and D; section E must be completed by your employer. For grant consideration, mail completed forms along with required documentation (see Mailing Instructions below) to HEAB by May 31<sup>st</sup>. Applicants will be notified by June 30<sup>th</sup> whether or not they will receive a financial assistance award.

### Section A: APPLICANT INFORMATION

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_ Social Security Number\* \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

\*Social security number is required for reporting award disbursement to the IRS.

### Section B: EMPLOYMENT INFORMATION

I am currently practicing as a physician or psychiatrist and my area of specialty or subspecialty is:

**Primary Care:**  Family Practice  Internal Medicine  General Surgery  Pediatric

**Psychiatry:**  Psychiatry  Child Psychiatry

Name of Employer or Affiliated Organization: \_\_\_\_\_

Work Address (physical location): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date employment offer accepted: \_\_\_\_\_ Date employment began: \_\_\_\_\_

**Section C: PRACTICING IN AN UNDERSERVED AREA**

Through employment listed in section B, I am currently practicing in the following type of underserved area: *Note: If HPSA, the HPSA designation must be in your discipline (primary care or mental health).*

- HPSA-Geographic Area                       HPSA-Population Group                       HPSA-Facility
- MUA/MUP                                       Governor’s Designated Shortage Area for Rural Health Clinics

Average number of hours per week that you are practicing in the underserved area(s): \_\_\_\_\_

**Section D: APPLICANT CERTIFICATION**

I certify that the information listed in sections A, B, and C is true.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Section E: EMPLOYER CERTIFICATION**

As a representative of the organization listed in Section B of this form, I certify that the information provided on this form is correct and the applicant is currently an employee or affiliated with this organization.

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Signatures must be originals---no electronic signatures or facsimiles will be accepted.**

**Mailing Instructions:** Mail the completed Claim for Assistance form to HEAB by May 31<sup>st</sup>. If this is the first time you are submitting a Claim for Assistance form, you must also provide proof of permanent license to practice medicine and surgery in the state of Wisconsin as well as proof of completion of a graduate medical training program in the state of Wisconsin in specialty or sub-specialty as indicated in section B. Applicants will be notified by June 30th whether or not they will receive a financial assistance award.

**Mail all documentation to:**  
HEAB-PCPSG  
PO Box 7885  
Madison WI 53707

**For questions, please contact:**  
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