State of Wisconsin
Higher Educational Aids Board

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Tony Evers
Governor

Connie Hutchison, PhD
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 31st. Applicants will be notified by June 30th 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 31st. 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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Email: joy.dyer@wisconsin.gov