Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Ricker Hamilton, Commissioner

Department of Health and Human Services
Licensing and Certification
41 Anthony Avenue
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-9300; Fax: (207) 287-9307
Toll Free (800) 791-4080; TTY Users: Dial 711 (Maine Relay)

Maine Tax Credit Certification for Primary Care Professionals
2017 TAX YEAR
INITIAL APPLICATION AND ATTESTATION FORM

PLEASE FILL OUT THIS TWO PAGE FORM COMPLETELY AND ATTACH ALL RELEVANT DOCUMENTS

*Mail a **single**, completed and signed form and supporting documentation to the Attention of: Director, Rural Health and Primary Care Program, at the letterhead address above. Please type or print legibly.* ***Only envelopes with a single (1) application will be considered for competitive review. Applications must be postmarked no earlier than January 16, 2018 and no later than February 15, 2018.***

FULL LEGAL NAME	

(Your legal name as used for professional licensure or federal and state tax purposes)

PERSONAL RESIDENCE ADDRESS					
STREET ADDRESS OR PO BOX					
CITY		**STATE**		**ZIP CODE**	
TELEPHONE		**EMAIL ADDRESS(ES)**			
MOBILE PHONE					

HEALTH PROFESSION INFORMATION

ELIGIBLE PROFESSIONAL TYPE – select one:

- ○ **Physician, M.D.**
- ○ **Doctor of Osteopathy D.O.**
- ○ **Physician Assistant, P.A.**
- ○ **Advanced Practice Registered Nurse A.P.R.N.**
- ○ **Certified Clinical Nurse Specialist C.N.S.**
- ○ **Certified Nurse Midwife C.N.M.**
- ○ **Certified Nurse Practitioner C.N.P**
- ○ **Registered Nurse R.N.**
- ○ **Licensed Practical Nurse L.P.N.**

Date Initially Licensed in Maine:_____

License Number_____

National Provider Identification Number (NPI)
_____

Please describe and attach proof of your unrestricted, active professional license, and any credentials or other authority demonstrating that you are trained and authorized to practice comprehensive primary care medicine as defined in rules adopted pursuant to 36 M.R.S. §5219-LL.

ATTESTATION – PRACTICE ESTABLISHMENT:

I attest that on (Date) _____, I began practicing primary care medicine full-time in the designated practice location identified on this form by:

- ○ Joining an existing primary care medicine practice.
- ○ Purchasing an existing primary care medicine practice.
- ○ Establishing a primary care medicine practice.

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Maine Tax Credit Certification for Primary Care Professionals
2017 Tax Year – Initial Application and Attestation Form

DESIGNATED PRACTICE LOCATION – PRECISE GEOGRAPHIC ADDRESS REQUIRED					
NAME OF PRACTICE					
PRIMARY CONTACT					
STREET ADDRESS					
CITY		STATE		ZIP CODE	
TELEPHONE		EMPLOYER FEDERAL TAX ID # (FEIN)			
MOBILE PHONE					
EMAIL ADDRESS(ES)					

DESIGNATED UNDERSERVED AREA TYPE: HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) OR MEDICALLY UNDERSERVED AREA OR MEDICALLY UNDERSERVED POPULATION

*You must **select one** Health Resources and Services Administration (HRSA) designation type **per application**.*

○ **POPULATION - HPSA** ○ **GEOGRAPHIC - HPSA** ○ **FACILITY - HPSA**

○ **Medically Underserved Area** ○ **Medically Underserved Population**

If you need to confirm your HRSA designation for your practice area, please refer to the Rural Health and Primary Care Program (Program) website maintained by the Maine Department of Health and Human Services, Division of Licensing and Regulatory Services, or contact the Program staff at the letterhead address.

REQUIRED SUPPORTING DOCUMENTATION CHECK LIST

I have attached the following required supporting documentation:

- ☐ **Proof of qualifying institutional student loan balance as described in rules adopted pursuant to 36 M.R.S. §5219-LL.**
- ☐ **Medicare or Medicaid Provider ID, or proof of application for enrollment in the Medicare or Medicaid programs.**
- ☐ **Proof of unrestricted professional license and credentials to practice primary care medicine.**
- ☐ **Incorporation documents, partnership agreements, employment agreement or other legal documents establishing business relationship with practice address.**
- ☐ **Documents that demonstrate proof of initiating and practicing primary care medicine at the designated location for 6 months prior to application submission.**

ATTESTATION – COMMITMENT TO PRACTICE

I attest that the following statements are true (please initial each statement):

_____ I intend to practice in the designated practice location identified on this form for five years.

_____ I have read and I understand the rules, conditions of eligibility and certification processes described in 10-144 CMR Chapter 298 and Title 36, M.R.S. §5219-LL.

_____ I understand that I may only be certified for the Primary Care Tax Credit Program for years in which I can demonstrate continued eligibility.

_____ _____

(Legal Signature) (Date)

Notice to Applicant: The Department of Health and Human Services may use information provided in this application to conduct a comprehensive background check as described in 22 M.R.S. §9053(3) . An application and attestation must be completed and submitted each year during the application period to determine continued eligibility. If certified, you are required to report to the Program if your practice location or any other condition of eligibility changes. The Program will confirm initial and continued eligibility requirements for each applicant upon receipt of a completed application every tax year. You must inform the Program if personal contact information or other information on this application changes within ten (10) days of actual knowledge of the change. Maine Revenue Services will receive confirmation of your certification. If you are certified, all questions involving filing your income tax or the amount of your tax credit must be directed to Maine Revenue Services at (207) 626-8475, P.O. BOX 1060, AUGUSTA, ME 04332, or income.tax@maine.gov.