

## **Maine Tax Credit Certification for Dental Care Professionals 2021 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

	rogram, DHHS – MeCDC, 11 State Ho								
Only envelopes with a single (1) application will be considered for competitive review. Applications must be postmarked no earlier than January 15, 2022 and no later than February 18, 2022.									
FULL LEGAL NAME	analy 13, 2022 and no all man 1	<i>cornary</i> 10, 20	, ,						
(Your legal name as used for professional licensure or federal and state tax purposes)									
PERSONAL RESIDENCE ADDRESS									
**You are required to contact the office if you have a change in contact information**									
STREET ADDRESS OR PO BOX									
CITY		STATE	ZIP CODE						
TELEPHONE			EMAIL ADDRESS(ES)						
MOBILE									
PHONE	PHONE								
HEALTH PROFESSION INFORMATION									
ELIGIBLE PROFESSIONAL TYPE – Select One:		Date Initially Licensed in Maine:							
☐ Dentist, D.M.D.									
Demist, D.W.D.		License Number:							
☐ Dentist, D.D.S.									
		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 dental care medicine.							
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:									
O Joining an exist	ting primary care medicine practice.								
C Purchasing an existing primary care medicine practice.									
C Establishing a	primary care medicine practice.								

**CONTINUE TO PAGE 2** 

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DESIGNATED PRACTICE LOCATION – PRECISE GEOGRAPHIC ADDRESS REQUIRED								
	**You are rec	equired to contact the office if yo	our practice information ch	anges**				
NAME OF PRACTICE								
PRIMARY CONTACT								
STREET ADDRESS								
CITY			STATE	ZIP CODE				
TELEPHONE			EMPLOYER FEDERAL TAX	,	1			
MOBILE PHONE			ID # (FEIN)					
EMAIL ADDRESS(ES)				HOURS PER WEEK I PATIENTS:				
WHAT PERCENTAGE OF	F THE PROVIDER'S CAS	SELOAD IS MAINECARE P		TITIE (15)				
WHAT PERCENTAGE OF	F VISITS ARE BILLED O	ON A SLIDING FEE DISCOU	INT BASIS?					
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.								
C POPULATION - HPSA C GEOGRAPHIC - HPSA C FACILITY - HPSA								
C Medically Underserved Area C Medically Underserved Population								
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-DD.								
http://legislature.maine.gov/legis/statutes/36/title36sec5219-DD.html  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 dental care medicine from								
https://www.pfr.maine.gov/almsonline/almsquery/SearchIndividual.aspx.  Incorporation documents, partnership agreements, employment agreement or other legal documents establishing business relationship								
with practice address.								
Documents that demonstrate proof of initiating and practicing dental care medicine at the designated location for 6 months prior to application submission.								
ATTESTATION – CO	MMITMENT TO PR	RACTICE						
I attest that the following statements are true (please initial each statement):								
I intend to practic	ce in the designated pr	ractice location identified	on this form for five	years.				
I have read and I understand the conditions of eligibility and requirements as described in Title 36, M.R.S. §5219-DD. <a href="http://legislature.maine.gov/legis/statutes/36/title36sec5219-DD.html">http://legislature.maine.gov/legis/statutes/36/title36sec5219-DD.html</a> and our instructions.								
I understand that I may only be certified for the Dental 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

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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 <a href="maintenance.com/income.tax@maine.gov">income.tax@maine.gov</a>.