



**Maine Tax Credit Certification for Primary Care Professionals
2020 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, DHHS – MeCDC, 11 State House Station, Augusta, ME 04333-0011. 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 15, 2021 and no later than February 18, 2021.***

FULL LEGAL NAME	
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(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 your contact information changes			

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

HEALTH PROFESSION INFORMATION

ELIGIBLE PROFESSIONAL TYPE – select one: <input type="radio"/> Physician, M.D. <input type="radio"/> Doctor of Osteopathy D.O. <input type="radio"/> Physician Assistant, P.A. <input type="radio"/> Advanced Practice Registered Nurse A.P.R.N. <input type="radio"/> Certified Clinical Nurse Specialist C.N.S. <input type="radio"/> Certified Nurse Midwife C.N.M. <input type="radio"/> Certified Nurse Practitioner C.N.P. <input type="radio"/> Registered Nurse R.N. <input type="radio"/> 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 .
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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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DESIGNATED PRACTICE LOCATION – PRECISE GEOGRAPHIC ADDRESS REQUIRED				
You are required to contact the office if your practice information changes				
NAME OF PRACTICE				
PRIMARY CONTACT				
STREET ADDRESS				
CITY		STATE		ZIP CODE
TELEPHONE			EMPLOYER FEDERAL TAX ID # (FEIN)	
MOBILE PHONE				
EMAIL ADDRESS(ES)			PROVIDER'S HOURS PER WEEK WITH PATIENTS:	
WHAT PERCENTAGE OF THE PROVIDER'S CASELOAD IS MAINECARE PATIENTS?				
WHAT PERCENTAGE OF VISITS ARE BILLED ON A SLIDING FEE DISCOUNT BASIS?				
DESIGNATED UNDERSERVED AREA TYPE: HEALTH PROFESSIONAL SHORTAGE AREA (HPSA) OR MEDICALLY UNDERSERVED AREA OR MEDICALLY UNDERSERVED POPULATION				
You must <u>select one</u> Health Resources and Services Administration (HRSA) designation type <u>per application.</u>				
<input type="radio"/> POPULATION - HPSA		<input type="radio"/> GEOGRAPHIC - HPSA		<input type="radio"/> FACILITY - HPSA
<input type="radio"/> Medically Underserved Area		<input type="radio"/> Medically Underserved Population		
REQUIRED SUPPORTING DOCUMENTATION CHECK LIST				
I have attached the following required supporting documentation:				
<input type="checkbox"/> Proof of qualifying institutional student loan balance as described in rules adopted pursuant to 36 M.R.S. §5219-LL . <input type="checkbox"/> Medicare or Medicaid Provider ID, or proof of application for enrollment in the Medicare or Medicaid programs. <input type="checkbox"/> Proof of unrestricted professional license and credentials to practice primary care medicine. <input type="checkbox"/> Incorporation documents, partnership agreements, employment agreement or other legal documents establishing business relationship with practice address. <input type="checkbox"/> 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.