Instructions for Employers: How to Complete the ISAC Employer Verification Form

Community Behavioral Health Care Professional Loan Repayment Program

Thank you for assisting your employee with the employment verification process for this loan repayment program. Please follow the steps below to complete the Employer Verification Form:

Step 1: Complete the Required Fields

Fill out all applicable fields on the form, including:

- **Applicant Name:** Your employee's information. First name, middle initial, last name.
- **Employer Name, Address, City/State/ZIP:** The name of your agency/organization or facility and location information.
- **HPSA Score:** The Mental Health HPSA score provided by the U.S. Health Resources and Services Administration. Please enter the score provided, and if your organization is not in a HPSA area, please enter ZERO (0).
- **Employment Information:** The employee's start date. If currently employed, please select that box. If no longer employed, please list the employee's end date.
- **Job Title:** The employee's job title in your organization. If you are a former employer and the applicant is no longer employed, please list the last job title held by the applicant.
- **Employer Certification Statement:** The employer representative completing this form should complete this final section. The employer can determine who is authorized to complete this form.

Step 2: Review for Accuracy and Completion

Ensure all information provided is accurate and reflects the applicant's employment details with your agency/organization or facility. Incomplete or inaccurate forms will lead to application processing delays and could result in the applicant being found ineligible for this program.

Step 3: Sign and Date the Form

The authorized employer representative must **sign and date** the form.

Step 4: Return the Form

Return the completed form to the applicant for inclusion in their application materials.

Illinois Student Assistance Commission
Community Behavioral Health Care Professional
Loan Repayment Program
Employer Verification Form

WARNING: Any person who knowingly makes a false statement or misrepresentation on this form shall be subject to prosecution to the fullest extent of the law.

The Community Behavioral Health Care Professional Loan Repayment Program requires that an applicant have worked for at least 12 consecutive months immediately prior to applying for this program as a behavioral health professional in a community mental health center, behavioral health clinic, substance use treatment center, or state-operated psychiatric hospital licensed or certified by the Illinois Department of Human Services or the Illinois Department of Healthcare and Family Services in an underserved, or rural Illinois health professional shortage area (HPSA).

INSTRUCTIONS: This form can be used by an applicant's current or former employer to provide employment information on the applicant. The applicant's EMPLOYER must complete and sign this form on the applicant's behalf. Once completed, the form may be returned to the employee for inclusion in their application submission. Please note that information gathered on this form is required for determining program eligibility so please ensure accurate responses. An applicant cannot be considered for an award until the completed application (which includes this form) is received by ISAC.

APPLICANT INFORMATION

APPLICANT NAME

EMPLOYER INFORMATION

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY/STATE/ZIP

EMPLOYER HPSA SCORE

(*If you do not know your Mental Health HPSA score, please use the **Find Shortage Areas by Address** search tool, located at: https://data.hrsa.gov/tools/shortage-area/by-address. If your facility is not in an HPSA area, please enter 0 (ZERO).*)

APPLICANT'S EMPLOYMENT INFORMATION

Employment Start Date

Employment End Date **OR** Currently Employed

Job Title

EMPLOYER CERTIFICATION (TO BE SIGNED BY THE EMPLOYER)

By providing a signature below, I certify that (1) the information in this document is true, complete, and correct to the best of my knowledge and belief, (2) I am an authorized representative of the organization named in this document, and (3) the applicant named in this document is or was an employee of the organization named in this document.

Employer Representative Name

Employer Representative Job Title

Employer Representative Phone

Employer Representative Email

Signature Date