Maryland Higher Education Commission
Office of Student Financial Assistance
6 North Liberty Street, Ground Suite
Baltimore, Maryland 21201
410-767-3300; 800-974-0203

Maryland
DEPARTMENT OF HEALTH

Maryland Department of Health
Office of Oral Health
201 W. Preston Street, 4th Floor
Baltimore, Maryland 21201
410-767-3081

Letter of Understanding

Applicant Information (please print or type)

Last Name _____ First Name _____ MI _____

Telephone _____ Email Address _____

The individual listed above is applying for the *Maryland Dent-Care Loan Assistance Repayment Program (MDC-LARP)*. This program seeks to increase dental access for Maryland Medical Assistance Program (MMAP) recipients. By agreeing to be part of this program, the individual listed above agrees that in return for school loan repayment, a minimum of 30% of their patient population will be Maryland Medical Assistance Program recipients for three (3) years.

By signing this you are acknowledging that the individual listed above is permitted to use your dental practice site to meet this 30% goal. You also agree to have the MDC-LARP Program Administrator conduct a yearly scheduled site visit to confirm that the practice site exists and to explain how the program works. There will be some minimal record keeping that will need to be done to ensure that the individual is meeting their 30% goal.

If you have any questions prior to signing this agreement, please do not hesitate to contact Stacy Costello at Stacy.Costello@maryland.gov. Please have the owner(s)/employer(s) sign below.

1. _____ Owner(s)/Employer(s) Signature _____ Date

_____ Print Name _____ Title

2. _____ Owner(s)/Employer(s) Signature _____ Date

_____ Print Name _____ Title

Practice Name: _____

Address: _____

Telephone Number: _____

NOTE: This form must be received by **July 30, 2021**.