

Guide – Employer Sponsorship

Purpose

The Employer Sponsor Form serves as an employer's official endorsement of a healthcare professional's participation in the HWEP. It documents the professional's employment details and confirms credential verification.

Instructions

General

- Complete all fields fully and accurately. Incomplete forms may delay review.
- Enter "N/A" if a question does not apply.
- Submit this form with the Healthcare Professional Application.

Section 1: Employer and Professional Information

1. **Employer Name:** Provide the official name of the employing organization.
2. **Primary Address:** Include the complete mailing address.
3. **Authorized Representative:** List the name of the individual designated to act on behalf of the organization for HWEP-related matters.
4. **Contact Phone and Email:** List the representative's direct phone number and email address.
5. **Professional's Name:** Enter the professional's full legal name.
6. **Start Date:** Indicate the professional's employment start date
7. **Discipline:** Specify the healthcare discipline (e.g., Physician, Dentist, LCSW)
8. **Job Title:** List the professional's official job title.
9. **Position Type:** (select one)
 - a. Regular: Standard roles.
 - b. Very Hard to Fill: Attach the required Very Hard to Fill Position Request Form.
10. **Award Type:** Indicate which incentive(s) the employer will sponsor.
 - a. Loan Repayment: Payment issued for payment of a qualified educational loan.
 - b. Direct Incentive: Payment issued directly to the professional.
 - c. Either
11. **Service Level:** Mark the appropriate level based on work hours.
 - a. Full Time: at least 36 hours per week, in 3 or more days
 - b. Half Time: at least 20 hours per week, in 2 or more days

Section 2: Professional Verification

Confirm completion of all the following, as required under 7 AAC 24.021:

1. **Reference Checks:** Validate professional qualifications and experience.
2. **Licensure/Certification:** Ensure the professional holds active and current licensure.
3. **National Practitioner Data Bank (NPDB):** Confirm no disciplinary actions or adverse records.
4. **Citizenship Verification:** Confirm U.S. citizen or permanent residency.
5. **Residency Verification:** Confirm the professional's primary domicile is in Alaska.

Section 3: Required Attachments

Complete and attach the following documents to the form:

1. **12-Week Work Hours Form:** Details of professional’s standard work hours.
2. **Employer Worksites Form:** List of each work location where professional will work.
3. **Position Description:** A detailed description of professional responsibilities.
4. **Very Hard to Fill Position Request:** If applicable, include this form to justify the designation.

Section 4: Employer Commitment and Certification

- **Signature and Date:** The Authorized Representative must sign and date to certify that all information is accurate, and that the employer is committed to complying with HWEP program requirements.

Employer Sponsorship

Section 1: Employer and Professional Information

Employer Name: _____

Primary Address: _____

City, State, ZIP Code: _____

Authorized Representative: _____

Phone: _____ **Email:** _____

Professional Name: _____ **Start Date:** _____

Discipline: _____ **Job Title:** _____

Position Type:

Award Type:

Service Level:

Section 2: Professional Verification

The employer confirms the following professional verifications were completed:

- Reference Checks:** Verified qualifications, experience, and role suitability.
- Licensure/Certification:** Confirmed active licensure/certification to practice in Alaska.
- National Practitioner Data Bank:** Confirmed no adverse actions or disciplinary measures.
- Citizenship Verification:** Verified U.S. citizenship or permanent residency.
- Residency Verification:** Confirmed professional's primary domicile is in Alaska.

Section 3: Required Attachments

Please complete and attach the following documents:

- 12-Week Work Hours Form:** Details of the professional's standard work hours/schedule.
- Employer Worksites Form:** List of each work location where professional will work.
- Position Description:** A detailed description of professional responsibilities.
- Very Hard to Fill Position Request:** If applicable, include to justify the position's designation.

Section 4: Employer Commitment and Certification

I certify that I am authorized to approve this professional's participation in the Healthcare Workforce Enhancement Program and that all verifications in Section 2 have been completed. I understand that, upon execution of a Memorandum of Agreement (MOA), the employer is responsible for:

1. **Supporting the Professional** – Providing the resources needed to meet program obligations.
2. **Funding Contributions** – Fulfilling financial obligations outlined in the MOA and HWEP guidelines.
3. **Ensuring Compliance** – Meeting all reporting, documentation, and verification requirements

Signature: _____ **Date** _____

12-Week Work Hours

Professional's Name: _____

Instructions:

Please provide the following details for each week of the professional’s standard 12-week work schedule. Only include time at approved sites:

- **Days Worked:** Number of days the healthcare professional works that week.
- **All Hours Worked:** Total hours worked during the week.
- **Direct Patient Care Hours:** Includes **BOTH in-person and telehealth** services.
- **Telehealth Hours:** Direct patient care hours dedicated **specifically to telehealth services**.
- **Comments:** Any relevant notes or explanations.

Note: A workweek begins Sunday at 12:00 AM and ends Saturday at 11:59 PM.

Week	Days Worked	All Hours Worked	Direct Patient Care Hours	Telehealth Hours	Comments
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					

Employer Worksites

Professional's Name: _____

Instructions:

- List each work location, with address, where the professional will claim work hours toward HWEPP participation.
- Eligible sites will be included as *Attachment A: Approved Employer Sites* of the Healthcare Professional Memorandum of Agreement (MOA).
 - **NOTE:** Only time spent at sites listed in Attachment A will count toward service level requirements.

Site	Site Name	Site Address
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
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