

**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  
and Mental Hygiene**  
Office of Oral Health  
201 W. Preston Street, 4<sup>th</sup> Floor  
Baltimore, Maryland 21201  
410-767-3081

## Letter of Understanding

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### Applicant Information (please print or type)

_____	_____	_____
Last Name	First Name	MI
_____	_____	_____
Telephone	Email Address	

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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 (410) 767-3081 or 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 31, 2015**.