BIRTHING WORKFORCE RETENTION FUND

Application Deadline: Must be received via email or USPS by 4/18/2025

STEP 1 : **Please fill in this page legibly or type.**

Applicant Name ______________________________

Clinical Practice or Business Name ______________________________

Business Address ______________________________

Phone # ______________________________

Email address ______________________________

Amount requested (must be between $5,000 and $10,000) ____________________

Calendar Year	Number of NM Medicaid and Indigent Patient Deliveries you attended	% of total deliveries attended	Number of NM Non- Indigent Patient Deliveries *(private insurance, non-indigent self-pay)*	% of total deliveries attended	Total payments and other funding received for all deliveries
2024					**$**
2023					**$**

Current individual annual malpractice premium cost (verified by current or most recent billing statement) $ ______________

State of New Mexico Vendor Number (if you have one) ______________________

The above information and the enclosed documents are accurate to the best of my knowledge. If awarded, my intention is to continue to practice full scope maternity care in NM, including deliveries, for at least one year following the award. I understand that I may not use this award towards any tail coverage policy, and I will apply this award only to my individual malpractice insurance policy.

______________________________ ____________________

Signature Date

NOTICE: This page lists required documentation to include with your application. Incomplete applications will not be considered.

STEP 2: Please submit the following along with your application:

1. A copy of your current malpractice liability insurance declaration page showing coverage including coverage for birthing services.
2. Convincing evidence of the number of NM Medicaid-insured and indigent patients you have delivered in the previous two years.
   (DO NOT SEND PHI/PI, PLEASE DE-IDENTIFY)
3. Convincing evidence of the number of NM privately insured patients and non-indigent self-pay patients you have delivered in the previous two years.
   (DO NOT SEND PHI/PI, PLEASE DE-IDENTIFY)
4. Convincing evidence of all payments and any funding you have received for delivery services for the previous two years.
5. Convincing evidence that you provide both prenatal and birthing services in your practice.
6. (Optional) Any additional information in support of your application for this award.

STEP 3:

Complete an NM Substitute W-9 form and return with application.
Applications submitted without a W-9 form will be considered incomplete.

Step 4:

Mail* or email completed application and supporting documents to:

Birthing Workforce Retention Fund
Attn: Maternal Health Program
2040 S. Pacheco St
Santa Fe, NM, 87505
doh-maternalhealth@doh.nm.gov

***If the application is submitted by mail, please send a confirmation email to the email address listed above so that we can anticipate the arrival of your application.**