Hawaii State Loan Repayment Program

Health Professional Application

General Information

The Hawaii/Pacific Basin Area Health Education Center is pleased to announce the Hawaii State Loan Repayment Program (HSLRP), a grant funded program. The State Loan Repayment Program will offer primary care and behavioral health care providers who work at non-profit organizations that are designated Health Professional Shortage Areas (HPSAs) in Hawaii assistance in repayment of educational loan debt.

Who's Eligible? Primary care physicians (allopathic/osteopathic); primary care advanced practice nurse practitioners; certified nurse-midwives; primary care physician assistants, health service psychologists, licensed clinical social workers, licensed professional counselors, marriage and family therapists. Primary care specialties for physicians are considered: Family Medicine, Internal Medicine, Pediatrics, Obstetrics/Gynecology, Geriatrics and Psychiatry. Primary Care Specialties for Nurse Practitioners and Physician Assistants are: Adult, Family, Pediatrics, Psychiatry/mental health, Geriatrics and Women's health. Applicants must be United States citizens or U.S. Nationals, have no outstanding contractual obligation for health professional services to the Federal Government, State or other entity, no judgment lien against their property for a debt to the U.S. government and not be excluded, debarred, suspended, or disqualified by a Federal agency. Initial eligibility will be evaluated through background and credit checks. Awarded recipients will be selected by a subcommittee of the Hawaii Medical Education Council.

All selected will be obligated to commit to 2 years of fulltime service or 4 years of halftime service at HSLR sites. HSLR sites are public or non-profit private entities located and providing health services in primary care health professional shortage areas (HPSAs). These include federally-qualified health centers, rural health clinics, critical access hospitals, long-term care facilities, community outpatient facilities, free clinics, school based health clinics, state or federal correctional facilities and nonprofit solo or group practices in geographic HPSAs. A list of the HPSA locations can be viewed at http://hpsafind.hrsa.gov/. Your site can qualify, even with a HPSA score of 0!

In addition to caring for the community they serve, recipients are expected to be involved with workforce development activities, including health career recruitment and teaching and behavioral health. The Hawaii Student Loan Repayment Program is expected to improve the number of primary care providers in medically underserved areas of Hawaii, as well as improve the retention of health care providers in medically underserved areas by lessoning the burden of large debt.

Please note, this is a grant funded program so continuation of State Loan Repayment funding from year to year is subject to continuation of federal grant funds. For this reason we cannot commit to fund past the initial year of commitment, but if you agree to participate, you will be obligated for the full time of initial service (2 years fulltime or 4 years halftime) if funding ends. Having said that we expect to continue on a year to year contract by mutual agreement after the initial commitment is met.

Instructions for Submitting an Application

- Applications will be accepted on a monthly basis, on the first of every month. Contracts will be awarded on a competitive basis.

- Before submitting an application, please speak with the Human Resources unit or Recruiter at your prospective site to ensure that they are willing to participate in the program and support your application submission.

- Please go to www.ahec.hawaii.edu to download application materials, follow the instructions, sign and send to our mailing address (below) or fax to 808-692-1258.

- The following documents MUST BE submitted in order for an application package to be considered complete:
  1. Completed Application;
  2. Personal Statement, Part D of the application;
  3. Certification of Practice Site, Part G of the application;*****
  4. A letter of recommendation from the practice site; *****
  5. Educational Debt Reporting Form, Part F of the application;
  6. Copy of current lender statements (dated within one month of applications submission) for each loan to be included in the loan repayment. The lender statement must include the applicant's name, current balance, account number, and the mailing address of the lender.
  7. Copy of current license or certification

  ***If practice site not finalized, please contact AHEC Office at 808-692-1060.**

- Mail/fax application package to:
  - Hawaii Pacific Basin AHEC
HAWAII SLRP
651 Ilalo St MEB 224M
Honolulu, HI 96813-5525
Fax 808-692-1258

- Notification of award will be sent out within 8 weeks following submission of complete application and background and credit checks. Please read the application instructions very carefully.
- If you would like assistance to determine whether or not your facility is located in a Health Professional Shortage Area, please contact (808) 692-1060.

If you have questions regarding the application or eligibility, please e-mail the Program Administrators withy@hawaii.edu and rhondaro@hawaii.edu or call staff via telephone at (808) 692-1070.

Hawaii State Loan Repayment Program

Health Professional Application *2018 – 2019 Grant Period*

Please refer to the application instructions before you begin. Complete each part of the application form. Make sure all supporting documents are submitted with your application.

PART A: PERSONAL INFORMATION

Last Name: ______________________ First Name: ____________________ Middle Initial: _______

Mailing Address: ____

City: ________________________ Country: _______________ State: ______ Zip: ________

Phone Numbers (provide at least 2): (_____) _______________ Hm ☐ Wk ☐ Cell ☐

(_____) _______________ Hm ☐ Wk ☐ Cell ☐

(_____) _______________ Hm ☐ Wk ☐ Cell ☐

Email Address: _____________________________ Wk ☐ Personal ☐

Social Security Number: ________________ HI Driver's License/ID Number: ___________________

Date of Birth: ________________________ Gender: Male ☐ Female ☐

Race/Ethnicity:

American Indian or Alaska Native ☐ Hispanic or Latino ☐

Asian ☐ Native Hawaiian or Other Pacific Islander ☐

Black or African American ☐ White or Caucasian ☐

Other* ☐ *Please specify: ____

List languages you speak, read, and or write in addition to English (check all that apply):

1. _____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐
2. _____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐
3. _____________________ Speak ☐ Read ☐ Write ☐ Basic medical training ☐

For Office Use Only:

Application Rec'd: __________________ Postmark Date: ______________ Reviewed by: _____________

Application: Complete ☐ Incomplete ☐ Ineligible ☐ Applicant cleared by: NHSC ☐ NHHSP ☐

Site Type: Public ☐ Private, Not-for-profit ☐ Description of Practice Site: ____________________

Site application: On File ☐ On NHSC List ☐ If on NHSC list, documentation attached: Yes ☐

Comments:

Applicant Name: ____

PART B: QUALIFICATIONS AND ELIGIBILITY

1. Are you a United States citizen? Yes ☐ No ☐
2. Do you have a current and unrestricted Hawaii license to practice your profession? Yes ☐ No ☐
3. Do you owe an existing service obligation to another entity? Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of application)
4. Are you free of judgments arising from Federal debt? Yes ☐ No ☐
   (If no, please provide explanation in your personal statements, Part D of application)
5. Are you delinquent with any court ordered child support? Yes ☐ No ☐
   (If yes, please provide explanation in your personal statements, Part D of application)
6. Are you an NHSC Scholar or Alumni? Yes ☐ No ☐
   (If yes, please provide the date that your NHSC service obligation was completed:________________)
7. Did you apply for the NHSC Federal Loan Repayment Program? Yes ☐ No ☐
   (If yes, please indicate the date of submission:________________)

PART C: HEALTH PROFESSION INFORMATION

(Indicate primary specialty)	MD	DO		NP	PA
Family Medicine	☐	☐	Adult	☐	☐
Internal Medicine	☐	☐	Family	☐	☐
Pediatrics	☐	☐	Pediatrics	☐	☐
Obstetrics/gynecology	☐	☐	Psychiatry/Mental Health	☐	☐
Geriatrics	☐	☐	Geriatrics	☐	☐
Psychiatry	☐	☐	Women's Health	☐	☐

School: ________________________ Date of Graduation: ________________________

City: ________________________ State: ______________ Zip: ____________

Postgraduate Training: ______________ Year Completed: ________________________

Board Eligible: ☐ Board Certified: ☐ Professional License #: ________ Certificate #: ________

PART D: PERSONAL STATEMENTS: Attach your personal statements to the application. Your statements must be typed and about one-page in length. Restate and number each question along with your answer.

1. Why do you want to participate in the Hawaii State Loan Repayment Program?
2. Describe the types of training or work experience you have had in a medical or mental Health Professional Shortage Area.
3. Describe any cultural competency training and/or life experience you may have (include number of units completed in college or CME).
4. If applicable, explanations for questions answered in Part B of this application.

PART E: QUESTIONNAIRE (optional)

1. Where did you hear about Hawaii's State Loan Repayment Program?
   - ☐ Work (employer/co-worker) ☐ State Loan Repayment Website ☐ Other Website: ______________
   - ☐ Family member, friend, or acquaintance ☐ Other source (please specify):______________
2. Where did you receive the Hawaii State Loan Repayment Program application form?
   - ☐ Work (employer/co-worker) ☐ State Loan Repayment Website ☐ Other Website: ______________
   - ☐ Family member, friend, or acquaintance ☐ Other source (please specify):______________

Applicant Name: ____

PART F: EDUCATIONAL DEBT REPORTING

DIRECTIONS:

- List source and amounts of outstanding educational loans used to finance your education. All spaces on this form must be completed even if the information appears on the lender statements that you will be submitting. Any missing information will make the entire application incomplete and it will not be reviewed.
- You must submit evidence of the educational debts listed below. If your loans have been consolidated, submit proof of consolidation.
- Current lender statements need to be dated within 30 days of submission and MUST include the current balance, account number, your name, and the address to which payment is submitted. Online printouts are acceptable as long as they include all of the required information.
- You may only submit proof of debt for those loans obtained during the course of your undergraduate or graduate education which led to your current license/certification as a qualified provider for this program. Make sure that the Lender Address listed below corresponds with the address to which payments are sent to. This address must also appear on the lender statements you have included in your application packet.

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1. Lender Name: ______________________________

Lender Address (send payments to): ______________________________

City: ____________________ State: __________ Zip +4: ____________

Account Number: ____________________ Current Loan Balance $ ____________

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2. Lender Name: ______________________________

Lender Address (send payments to): ______________________________

City: ____________________ State: __________ Zip +4: ____________

Account Number: ____________________ Current Loan Balance $ ____________

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3. Lender Name: ______________________________

Lender Address (send payments to): ______________________________

City: ____________________ State: __________ Zip +4: ____________

Account Number: ____________________ Current Loan Balance $ ____________

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4. Lender Name: ______________________________

Lender Address (send payments to): ______________________________

City: ____________________ State: __________ Zip +4: ____________

Account Number: ____________________ Current Loan Balance $ ____________

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5. Lender Name: ______________________________

Lender Address (send payments to): ______________________________

City: ____________________ State: __________ Zip +4: ____________

Account Number: ____________________ Current Loan Balance $ ____________

Applicant Name: ______________________________

PART G: CERTIFICATION OF PRACTICE SITE (to be filled out by practice site)

The completed form must bear an original ink signature and be returned with the provider's application. Photocopies and faxed copies are not acceptable. In addition, a supervisor or authorized representative must prepare a letter of recommendation explaining why the provider would be a good candidate for this program.

***If practice site not finalized, please contact AHEC Office at 808-692-1060.**

PARTICIPATING SITE INFORMATION

Please list the actual street address of the practice setting(s) where the applicant is working, or has entered into an agreement to services.

Site Name:____

Address: ____

City: ___________________________ County: _________________ Zip +4:___________________

Type of Practice: Public ☐ Private, not-for profit: ☐

Contact Person (person who will sign MOU below):________________________________

Title: ___________________________________ Telephone Number: (___)___________

Email address: ____

MEMORANDUM OF UNDERSTANDING (MOU) INFORMATION

As an approved practice site in the Health Professions Shortage Area (HPSA) in Hawaii where a participant in the Hawaii State Loan Repayment Program is or will be employed, the above named Site agrees to the following terms:

1. Site shall accept all public insurances, including Medicare, Medicaid, and all MedQuest programs (equivalent of Children's Health Insurance Program).
2. Site will provide discounts for individuals with limited incomes (i.e.: using a sliding fee scale) as outlined below:
   a. For those with annual incomes at or below 100 percent of the HHS Poverty Guidelines, Site shall provide services at no charge or at a nominal charge.
   b. For individuals between 100 and 200 percent of the HHS Poverty Guidelines, the Site shall provide a schedule of discounts, which should reflect a nominal charge coverage from a third party (either public or private).
   c. Site may charge for services to the extent that payment will be made by the third party.
3. Site will provide to the University of Hawaii the following:
   a. A copy of the patient fee schedule annually;
   b. A schedule of salaries paid to all professionals in the field of the Program Participant (on whose behalf the UH is repaying the loan) in order to demonstrate parity of payment to loan repayers;
   c. A monthly confirmation of full time employment of Program Participant.
   d. Optional: If applicant is awarded SLRP funding, our organization commits $___________ in cash to JABSOM to repay his/her educational debt, understanding that this will be matched dollar-for-dollar with federal money.

Site authorized fiscal official acknowledges and agrees to the above terms.

Signature: ____ Date: ____________________

Name: ____ Title: ____________________

Applicant Name: ____

PART H: APPLICATION CERTIFICATION

I certify that I am the person herein named subscribing to this application; that I have read the complete application, know the full content thereof, and declare under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct and that I am willing to sign, or have signed a written agreement with a practice setting committing to a minimum of two years of service. I authorize representatives of the University of Hawaii, John A. Burns School of Medicine, Hawaii Pacific Basin Area Health Education Center (UH JABSOM HPB AHEC) to contact educational institutions I attended, institutions holding any of the listed educational loans, and employers to verify the accuracy of the information contained in this application. I also authorize representatives of UH JABSOM HPB AHEC to investigate my background and qualifications which may obtain information relating to my criminal history record as well as obtain a copy of my credit report for purposes of evaluating whether I am qualified for the Hawaii State Loan Repayment Program for which I am applying. I understand that UH JABSOM HPB AHEC will utilize an outside firm(s) to assist it in checking such information, and I specifically authorize such an investigation by information services and outside entities of the company's choice. I also understand that I may withhold my permission and that in such a case, no investigation will be done, and my application for the State Loan Repayment Program will not be processed further.

The criminal history record, as received from the reporting agencies, may include arrest and conviction data as well as plea bargains and deferred adjudications and delinquent conduct committed as a juvenile. I understand that as long as I remain a participant, the criminal history records check and credit check may be repeated at any time.

I hereby affirm that my answers to the foregoing questions are true and correct and that I have not knowingly withheld any fact of circumstances that would if disclosed, affect my application unfavorably. I understand that false information submitted in this application may result in discharge.

I, the undersigned, do, for myself, my heirs, executors and administrators, hereby remise, release, and forever discharge and agree to indemnify the UH JABSOM and each of their officers, directors, employees and agents and hold them harmless from and against any and all causes of actions, suits, liabilities, costs, debts, and sums of money, claims and demands whatsoever (including claims for negligence, gross negligence, and/or strict liability of the UH JABSOM)and any and all related attorney's fees, court costs, and other expenses resulting from the investigation of my background in connection with my application to become a recipient of the Hawaii State Loan Repayment Program.

Signature: ______________________________ Date: ______________

Print Name: ______________________________

Submission Check List:

- ☐ Completed Application
- ☐ Personal Statements
- ☐ Certification of Participating Site
- ☐ Letter of Recommendation from Site
- ☐ Educational Debt Reporting Form
- ☐ Current Lender Statements
- ☐ Copy of Current License or Certification