Hawai‘i Healthcare Education Loan Repayment Program (HELP)
A Program of the State of Hawai‘i
2023-2024 HELP Application

General Information

The Hawai‘i/Pacific Basin Area Health Education Center is pleased to announce the Healthcare Education Loan Repayment Program (HELP), a program funded by the Hawai‘i State Legislature. HELP provides qualified educational loan debt repayment to health professionals licensed or otherwise certified to practice in Hawai‘i and provide care to patients in Hawai‘i. The Internal Revenue Service defines Qualified Educational Loans under 26 USC 221(d)(1). The State expects the HELP to help improve the number of providers in medically underserved areas of Hawai‘i, as well as improve the recruitment and retention of healthcare workers caring for the people of Hawai‘i by lessening the burden of large educational debt.

To qualify for HELP, applicants must be (or must become) a healthcare professional licensed or otherwise certified in Hawai‘i who provides clinical care to human patients living in Hawai‘i and accepts public insurance for at least 30% of their patient care claims. This can be measured in two ways as described in Section G of this document. For HELP purposes, the following are considered public insurance: Medicare Fee For Service, Medicare Advantage, Medicaid Fee For Service, QUEST Integration (Med-QUEST), Veterans Administration, and TRICARE.

Interns, residents, or fellows currently in professional training in one of the recognized health professions may apply. Terms of loan repayment and other HELP programmatic terms and conditions may differ from already licensed or certified healthcare professionals.

*Applicants must be United States citizens or lawful permanent residents, have no outstanding contractual obligation for health professional services to the Federal Government, 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 checks and credit checks.

Awarded participants will be selected by a subcommittee of the HELP Steering Committee. All applicants who are selected for the HELP program and choose to participate are obligated to commit to a minimum of two (2) years of full-time or half-time service at a site serving patients in Hawai‘i. In addition to caring for the community they serve, participants are encouraged to be involved with workforce development activities, including health career recruitment, teaching, or community health outreach.

Funding will be secured for the full contract amount. After the initial contract period, participants may be eligible to extend their contract. However, as this is a state-funded program, continuation from year to year is subject to the availability of funds appropriated by the state legislature.
Instructions for Applying

● Contracts will be awarded on a competitive basis. The highest priority will be given to primary care providers and behavioral health providers working throughout the state and to specialists in rural Hawai‘i as defined by Hawai‘i Revised Statutes XXX. Priority will also be given to other healthcare providers working in professions and areas for which there is a documented shortage.

● Please go to [www.ahec.hawaii.edu](http://www.ahec.hawaii.edu) to download application materials, follow the instructions, sign, and mail or fax to the address below. We are currently developing a secure online application process.

● The following documents MUST BE submitted for an application package to be considered complete:
  1. Completed Application, including all parts.
  2. Educational Debt Reporting Form, Part F of the application.
  3. Copy of current lender statements, dated within one month of application 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.
  4. If the current lender is not an educational lender (i.e. if you have refinanced your educational debt with a commercial lender), include your original educational debt documentation from the lending or educational institution.
  5. Copy of current Hawai‘i professional license or certificate (i.e., for certain technologists).
  6. Certification of Practice Site, Part G of the application; *
  7. Copy of a valid government-issued identification (such as passport or driver’s license)

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

An employment start date is required.

● Mail/fax application package to:
  Hawai‘i Pacific Basin AHEC
  Hawai‘i Healthcare Education Loan Repayment Program
  651 Ilalo St MEB 224M
  Honolulu, HI 96813-5525
  Fax 808-692-1258

● Please read the application instructions very carefully.

● If you would like assistance with completing the application, please contact Jenna at (808) 692-1060 or email ahec@hawaii.edu.

If you have questions regarding the application or eligibility, please email the Program Administrator or contact program staff via telephone at (808) 692-1060.
Healthcare Education Loan Repayment Program

Health Professional Application

2023-2024 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: .


Phone Numbers (provide at least 2): ( ) Wk Cell ( ) Wk Cell

Email Address: . Work/Personal

Social Security Number: . Identification number (license/passport): .

Date of Birth: . Gender: Male Female Other

How many hours of patient care to patients in Hawai‘i do you perform each week? _______________

Are you a veteran of the U.S. Armed Forces? Yes No

Race/Ethnicity:

The race/ethnicity information requested below is optional and will not be used for the purposes of evaluating your application. It will be used to satisfy federal and/or State of Hawaii reporting requirements and may be used for other purposes allowed by law. Please select all that apply.

American Indian or Alaska Native □ Hispanic or Latino □

Asian □ Native Hawaiian □

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 □
PART B: QUALIFICATIONS AND ELIGIBILITY

1. Are you a United States citizen or lawful permanent resident?  
   Yes ☐  No ☐

2. Do you have a current and unrestricted Hawai‘i license or state/national certification to practice your profession in Hawai‘i?  
   Yes ☐  No ☐

3. Are you free of judgments arising from Federal debt?  
   Yes ☐  No ☐
   (If no, please provide an explanation in your personal statements, Part D of the application)

4. Are you delinquent with any court-ordered child support?  
   Yes ☐  No ☐
   (If yes, please provide an explanation in your personal statement, Part D of the application)

5. Did you apply for the NHSC Federal Loan Repayment Program?  
   Yes ☐  No ☐
   (If yes, please indicate the date of submission:
   a. Do you owe an existing service obligation to another entity, or have you received any other loan repayment funding in the past?  
      Yes ☐  No ☐
      (i.e., National Health Service Corps, Department of Defense, Public Health Service)
   (If yes, please provide an explanation in your personal statements, Part D of the application)

PART C: HEALTH PROFESSION INFORMATION

Physician ☐  Specialty: _____________________
Nurse Practitioner ☐  Specialty: _____________________
Physician Assistant ☐  Specialty: _____________________
Acupuncturist ☐  Mental Health Counselor ☐
Athletic Training ☐  Midwife ☐
Audiologist ☐  Naturopathic Physician ☐
Certified Nurse Aide ☐  Registered Dietician ☐
Dental Hygienist ☐  Medical Assistant ☐
Dentist ☐  Nursing Home Administrator ☐
Psychologist ☐  Occupational Therapist ☐
Licensed Bachelor Social Worker ☐  Occupational Therapy Assistant ☐
**PART D: TIES TO HAWAIʻI**

*Please check all that apply to you.* If applicable, include brief additional information and explanations to questions below or in Part B of this application.

- [ ] Born in Hawaiʻi
- [ ] High school in Hawaiʻi
- [ ] College in Hawaiʻi
- [ ] Graduate or Professional education in Hawaiʻi
- [ ] Clinical Training in Hawaiʻi
- [ ] Work(ed) in Hawaiʻi. When / How long? __________________________
- [ ] Have family in Hawaiʻi
- [ ] Own a home in Hawaiʻi
- [ ] Teach health professions students
- [ ] Perform outreach activities in Hawaiʻi

**PART E: QUESTIONNAIRE (optional)**

*Where did you hear about Hawaii’s HELP?*

- [ ] Work (employer/co-worker)
- [ ] AHEC Website
- [ ] Other Website: 
- [ ] Family member, friend, or acquaintance
- [ ] Other source (please specify): 

PART F: EDUCATIONAL DEBT REPORTING

DIRECTIONS:

- List the 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. If your loans have been refinanced via a commercial lender, provide evidence of original educational loan debt.

- 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 if they include all the required information.

- You may only submit proof of debt for those loans obtained during your undergraduate or graduate education that 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. This address must also appear on the lender statements you have included in your application packet.

1. Lender Name:  
Lender Address (send payments to):  
City:  
State:  
Zip +4:  
Account Number:  
Current Loan Balance $.

2. Lender Name:  
Lender Address (send payments to):  
City:  
State:  
Zip +4:  
Account Number:  
Current Loan Balance $.

3. Lender Name:  
Lender Address (send payments to):  
City:  
State:  
Zip +4:  
Account Number:  
Current Loan Balance $.

4. Lender Name:  
Lender Address (send payments to):  
City:  
State:  
Zip +4:  
Account Number:  
Current Loan Balance $.

5. Lender Name:  
Lender Address (send payments to):  
City:  
State:  
Zip +4:  
Account Number:  
Current Loan Balance $.
PART G: CERTIFICATION OF PRACTICE SITE
(to be completed and signed 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. Examples of certifiers include the site owner, lead finance officer, or an authorized official of the employer.

PARTICIPATING SITE INFORMATION

Type of Practice: □ FQHC  □ Private solo Practice  □ Private group practice  □ Employed □ Locums
□ Other : ________________________________________________________________

If your main practice site is on O’ahu, but you routinely provide care on a neighbor island, please indicate how many days per month, on average, you provide this care: in-person ___  via telehealth ___

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

Primary Site Name: _____________________________________________________________
Address: _____________________________________________________________
City: ____________________________ County: ___________________ Zip +4: ____________________

Secondary Site Name: _____________________________________________________________
Address: _____________________________________________________________
City: ____________________________ County: ___________________ Zip +4: ____________________

*If you provide care in more than two sites, please provide the additional site information on a separate document.*

Contact Person (person who will sign MOU below):____________________________________________
Employer/Organization Name: ____________________________________________________________
Title: _____________________________________________ Telephone Number: __________________
Email address:_________________________________________________________________________

Applicant’s start date with the primary site or employer: ________________

For the purposes of this program, public insurance includes and is limited to Medicare Fee For Service, Medicare Advantage, Medicaid Fee For Service, QUEST Integration (Med-QUEST), Veterans Administration, and/or TRICARE (“Public Insurance”). As a participating practice site in HELP, the above-named practice site agrees to the following terms regarding acceptance of Public Insurance:

The practice site accepted Public Insurance for at least thirty percent (30%) of patient billing claims for the calendar year prior to the year for which loan repayment is being requested and continues to accept Public Insurance. The practice site reasonably believes that the percentage of Public Insurance accepted at the practice site shall be no less than thirty percent (30%) of claims on an annualized basis during the two-year service commitment of the participant in which the participant is providing services at the practice site. If the practice site is a multisite group practice, the percentage of the practice site’s Public Insurance claims shall be calculated based on an aggregate of all claims at all of the practice site’s locations.
If the participant has or is starting a private practice, the participant attests that the participant shall care for patients that in aggregate have thirty percent (30%) public insurance, with the percentage of Public Insurance accepted at the practice site to be no less than thirty percent (30%) of claims on an annualized basis for the duration of the Participant’s service commitment in which the Participant is providing services at the practice site.

Site or practice will provide to the University of Hawaiʻi the following:

a. An initial and quarterly confirmation of employment status of the HELP program participant.

b. Notification by phone to (808) 692-1060, or written notification to ahec@hawaii.edu, within seven business days, if the provider moves from this location.

Practice site, through its authorized official, acknowledges and agrees to the above terms as evidenced below.

Signature: .

Date: .

Name: _________________________________________________

Title: _____________________
PART H: APPLICANT 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 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 direct patient service on either a full-time (40 hours per week) or half-time (20 hours per week) basis.

I authorize representatives of the University of Hawai‘i, including but not limited to representatives from the John A. Burns School of Medicine, Hawai‘i 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 the University of Hawai‘i, only for the purpose of evaluating whether I am qualified for HELP to which I am applying, to obtain a copy of my credit report and investigate my background and qualifications, which may include obtaining information relating to my criminal history record. I understand that the University of Hawai‘i 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 occur, and my application for the HELP 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 if 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 my discharge and/or termination from HELP.

I understand that I am not allowed to receive loan repayment from an additional source that requires a commitment that may conflict with HELP (such as National Health Service Corps or State Loan Repayment Programs) during my participation in the HELP. I understand that the UH JABSOM HPB AHEC staff will periodically contact my practice site to verify employment.

I understand that if I fail to meet my service commitment to HELP, I will have to repay the University of Hawai‘i in the amounts and/or rates specified in my Applicant Terms and Conditions, which are the terms and conditions of HELP that each participant signs and agrees to upon acceptance and matriculation into HELP. Damages and penalty terms if I do not meet my service commitment would result in payment by me of an amount equal to: (A) the total amount of HELP support paid by the University of Hawai‘i for any period of service commitment I did not serve; (B) an amount equal to the product of the number of months of service commitment that I did not complete, multiplied by $5,500, but not to exceed two hundred percent (200%) of my total award amount; and (C) interest on the total amounts due under subsection (A), calculated at five percent (5%) per annum. Further, regardless of the above formula,
the total amount I will owe in damages shall not be less than $31,000 or 150% of my total award amount, whichever is less.

I, the undersigned, do, for myself, my heirs, executors, and administrators, hereby waive, release, and discharge any and all claims, demands, actions, rights, and causes of action for any and all illness, personal or bodily injury, death, economic and property damage, severe emotional loss, and any other loss, damage, or injury (collectively the “Injuries/Damages”), that I may sustain or suffer from the investigation of my background in connection with my application to become a participant of HELP (collectively the “Released Claims”).

I agree to indemnify, defend, and hold harmless the University of Hawai‘i, and its past, present and future Board of Regent members and University of Hawai‘i officers, employees, agents, and assigns from any and all Released Claims and any and all demands, actions, judgments, injunctions, orders, directives, penalties, assessments, liens, liabilities, losses, damages, costs, and expenses (including attorneys’ fees), arising or resulting from or caused by the investigation of my background in connection with my application to become a participant of HELP.

Signature: .

Date: .

Print Name: .

Submission Checklist:

☐ Completed Application  ☐ Part F. Educational Debt Reporting Form
☐ Copy of government-issued identification  ☐ Copy of health professions Current License or Certification
☐ Part G. Certification of Participating Site