Hawai'i State Loan Repayment Program

Health Professional Application

General Information

The Hawai'i/Pacific Basin Area Health Education Center is pleased to announce the Hawai'i 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 Hawai'i assistance in repayment of educational loan debt.

Who's Eligible?
Primary care physicians (allopathic/osteopathic); primary care advanced practice nurse practitioners; registered nurse; 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, Psychology, and Psychiatry. Primary Care Specialties for Nurse Practitioners and Physician Assistants are Adult, Family, Pediatrics, Psychology, Psychiatry /mental health, Geriatrics and Women's health. General and Pediatric Dentistry; Registered Dental Hygienists.
**Allied healthcare workers such as physical therapists/technicians, ultrasound technicians/technologists, genetic counselors.

*****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.

**Innovative Hawai'i State Loan Repayment Program – loan repayment to allied health professions that are in great need, but have not had the option for loan repayment in the past.

Initial eligibility will be evaluated through background checks and credit checks.

Awarded recipients will be selected by a subcommittee of the Hawai'i Medical Education Council.

All selected will be obligated to commit to 2 years of full-time service or 4 years of half-time service at HSLRP sites. HSLRP sites are public or non-profit private entities located and providing health services in primary care 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 non-profit 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 Hawai'i State Loan Repayment Program is expected to improve the number of primary care providers in medically underserved areas of Hawai'i, as well as improve the retention of health care providers in medically underserved areas by lessoning the burden of large debt.

*****We are asking employers to assist us in providing matching funds. This match will increase the total available to you for loan repayment and will increase your total award.**

Furthermore, this is a grant funded program, so continuation from year to year is subject to continuation of 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. We expect to continue the program on a year-to-year contract by mutual agreement after the initial commitment is met. **

Instructions for Applying.

- 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 or fax to address below.

- The following documents MUST BE submitted 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.**
    Employment start date is required.

- Fax application package to:
    - Hawai'i Pacific Basin AHEC
      HAWAI'I SLRP
      651 Ilalo St MEB 224M
      Honolulu, HI 96813-5525
      Fax 833-740-4152

- Please read the application instructions very carefully.
- If you would like assistance to determine whether your facility is 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 Administrator or contact program staff via telephone at (808) 692-1060.

Hawai'i State Loan Repayment Program

Primary Care Health Professional Application *2024 - 2025 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): ( ) _____ Wk. ☐ Cell ☐

( ) _____ 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 ☐

Veteran Status:

Veteran ☐ Active-Duty Military ☐ Not a Veteran ☐

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 Hawai'i license to practice your profession? Yes ☐ No ☐
3. Do you owe an existing service obligation to another entity? Yes ☐ No ☐
   (i.e., Native Hawaiian Health Scholarship, Department of Defense, Public Health Service)

   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	DT		NP	PA	LPC
Family Medicine	☐	☐		Adult	☐	☐	
Internal Medicine	☐	☐		Family	☐	☐	
Pediatrics	☐	☐		Pediatrics	☐	☐	
Obstetrics/gynecology	☐	☐		Psychiatry/Mental Health	☐	☐	☐
Geriatrics	☐	☐		Geriatrics	☐	☐	
Psychiatry	☐	☐		Women's Health	☐	☐	
Psychology	☐	☐		Psychology	☐	☐	
General and Pediatric Dentistry			☐				
				Registered Dental Hygienist	☐		

Other: _____
(Physical Therapists, Ultrasound techs/technologists, Genetic counselors)

School: _____ Date of Graduation: _____

City: _____ State: _____ Zip: _____

Postgraduate Training: _____ Year Completed: _____

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

NPI number:_____

PART D: PERSONAL STATEMENTS: *Attach your personal statements to the application. Your statements must be typed and about one-page in length. Number each question and state 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 if they include all the required information.
- You may only submit proof of debt for those ***loans obtained during 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 $ _____

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.

***START DATE OF EMPLOYMENT IS REQUIRED.**

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, the 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) to demonstrate parity of payment to loan repayers.
   c. A monthly confirmation of full-time employment of Program Participant.
   d. If your site is able to provide matching funding, please enter that here: $_____.

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

Signature: _____ Date: _____

Name: _____ Title: _____

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 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, 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 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 Hawai'i 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 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 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