

New Physician Subsidy Program

Health Professional Application

2019-2020

General Information

Community First, a Hawai‘i Island 501(c)(3) non-profit focused on improving wellness and designing health care solutions for Hawai‘i County, is the fiscal sponsor of a financial support program designed to recruit new physicians to bring their talents to Hawai‘i Island, sustain them in their practice, and encourage them to make Hawai‘i Island their home. Community First and their partners recognize the need in the community for primary care and specialty physicians. These new physicians often face financial obstacles and other challenges when they arrive here, however. In response, local health care institutions and community organizations have joined together to develop financial support packages that subsidize new physicians who are called to practice in the East Hawai‘i Community. There are two financial support programs available: the community-supported subsidy program and the hospital-supported subsidy program.

Community-supported subsidy program. The community-supported subsidy program’s financial support comes from multiple community sources. Subsidies of up to \$100,000 each to be distributed over the course of two years will be made available for these positions. Each physician recipient must be sponsored and mentored by an East Hawai‘i physician, who will team up with the new physician to assist with transition to Hawai‘i Island medical practice. Each physician recipient commits to a three-year obligation of fulltime service in the East Hawai‘i region.

Hospital-supported subsidy program. The hospital-supported subsidy program’s financial support comes entirely from Hilo Medical Center. This program will support one physician specialist where there is a high need in the community and in the hospital for this physician’s services. A subsidy of 50% of the Medical Group Management Association’s most recent non-hospital based median salary survey for that specialty will be provided for a two-year period, and paid out as a grant on a quarterly basis as long as the physician continues practicing during the quarter. Each physician recipient must be sponsored and mentored by an East Hawai‘i physician, who will team up with the new physician to assist with transition to Hawai‘i Island medical practice. Because the hospital is a state-supported institution that provides care to patients without regard to insurance or ability to pay, the selected physician will be required to have a practice that is open to Medicaid patients during the two-year subsidy period. In addition, in order to provide essential safety net-services to the community, the selected physician will be required to take an equal amount of call for all patients regardless of their

ability to pay, if other physicians in his or her specialty take call at Hilo Medical Center. There is additional reimbursement from Hilo Medical Center, outside of this program, for providing call coverage. The selected physician specialist commits to a three-year obligation of fulltime service in the East Hawai'i region.

Eligibility. To be eligible for these grants, applicants must be physicians new to the East Hawai'i Region service area (i.e. not currently practicing in the East Hawai'i Service area prior to applying for these grants) or residents completing training in the HHSC Hawai'i Island Family Medicine Residency. (See service area map at appendix A). Applicants are required to obtain a sponsoring physician in good standing in the East Hawai'i region in order to apply (see application instructions for more details).

Applicants must be a U.S. Citizen or a U.S. National and have no outstanding contractual obligation for health professional services to the Federal Government, State or other entity.

Initial eligibility will be evaluated through background and credit check. Applications will be reviewed by a selection committee and awards granted by Community First. Physicians selected must be aware that they are obligated to fulltime service in the East Hawai'i Region beyond the financial support period.

The financial support selection process involves a series of steps, listed below:

The **financial support selection process** involves a series of steps: 1) Community First advertises the financial support program with the support of community partners; 2) New physicians connect with an East Hawai'i physician (requirement for application); 3) New physicians and sponsoring/mentoring physicians fill out an application; 4) Applications reviewed by Community First Selection Committee; 5) Selection Committee makes a recommendation and forwards to Community First for a decision; 6) If appropriate, Community First makes offer to new physician; and 7) New physician commits.

The selection committee deliberations will factor more highly in such areas as: (for new physician) funding type requested, medical expertise, specialty, likelihood of success in rural practice, credit-worthiness, and for the community-supported subsidy, whether the applicant is an HHSC resident; and (for sponsoring physician) commitment to the program.

Instructions to New Physician for Submitting an Application

Applications will be accepted on a rolling basis. Complete application packets are received at the Community First address listed below. Incomplete or partial applications will not be accepted. Financial support will be awarded on a competitive basis.

Before submitting an application, a sponsoring physician in good standing with the East Hawai'i region must be obtained. ***Please speak with your sponsoring physician to ensure that they are willing to commit to the program and support your application.***

The following documents must be submitted with your application package to be considered complete.

1. Completed Application
2. Personal Statement, Part C of the application
3. Letter of Recommendation from the sponsoring physician
4. Copy of current medical license(s) for New Physician
5. Copy of board certification(s) for New Physician, if available
6. Copy of CV for New Physician
7. Statement from Sponsoring Physician
8. Copy of CV for Sponsoring Physician
9. Copy of current medical license(s) for Sponsoring Physician
10. Copy of board certification(s) for Sponsoring Physician, if available

New Physician will mail or hand deliver application package to:

Community First
670 Ponahawai Street, Suite 117
Hilo, Hawai'i 96720

Notification of award will be sent out by within 60 days of review, following favorable background and credit check results. **Please read the application instructions very carefully.**

If you have any questions regarding the application, eligibility, or East Hawai'i region sponsors, please email the Program Administrator at kkobayashi@communityfirst.co (include "New Physician Subsidy" in the subject line) or contact the program staff via telephone at (808) 756-9637 or (808) 785-9579.



Community First New Physician Subsidy Program

2019-2020 New Physician Subsidy Application

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 ___

Email Address: _____ Wk ___ Personal ___

*Social Security Number: _____

Date of Birth: _____ Gender: Male ___ Female ___

List language 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 ___

PART B: QUALIFICATIONS AND ELIGIBILITY

1. Do you have a current and unrestricted medical license to practice your profession?

(If no, please provide explanation in your personal statements, Part C of application)

Yes ___ No ___

2. Do you owe an existing service obligation to another entity?

(If Yes, please provide explanation in your personal statements, Part C of application)

Yes ___ No ___

3. Are you free of judgments arising from Federal debt?

Yes ___ No ___

(If No, please provide explanation in your personal statements, Part C of application)

4. Are you delinquent with any court ordered child support?
Yes _____ No _____
(If Yes, please provide explanation in your personal statements, Part C of application)
5. Are you a National Health Service Corps (NHSC) Scholar or Alumnus?
Yes _____ No _____
(If Yes, please provide the date that your NHSC service obligation was completed: _____)
6. Did you apply for the NHSC Federal Loan Repayment Program
Yes _____ No _____
(If Yes, please provide the date of submission: _____)
7. Are you currently a Family Medicine Resident in the Hawaii Health Systems Corporation's Primary Care Training Program?
Yes _____ No _____
8. Please attach: Medical background including CV, copy of Medical License and Board Certification
(if available) for new physician.

PART C: PERSONAL STATEMENT: Attach your personal statement to the application. Your statement must be typed and not more than two pages in length. Restate and number each question along with your answer.

Tell us about yourself and your goals and include answers to the following questions:

1. Why do you want to practice in the Hilo area?
2. How do you envision the scope of your practice in 5 years?
3. If new to the area, how do you plan on spending your first week here or how did you spend your first week?
4. If you have made any previous visits to the Hilo area, how many times have you visited and how long was each visit?
5. If you have made any previous visits to other parts of Hawai'i, where did you go, and how long did you stay there?
6. Have you had any educational, work, or personal experiences that you feel prepares you for a practice in a rural part of Hawai'i?
7. Are there any areas of concern with a move to the Hilo area?
8. Any other information that you think would be helpful in evaluating your financial request?
(please attach)
9. Any other information that you think would be helpful in evaluating your application? (please attach)
10. Planned practice including specialty and any other areas of concentration for new physician.

PART D: FINANCIAL SUPPORT REQUESTED: Requested Financial Support going directly to the new physician. Check the preferred type of support.

Community-sponsored subsidy

Hospital-sponsored subsidy

Applying to both programs

PART E: APPLICATION CERTIFICATION

I certify that I am the person herein subscribing to this application; that I have read the complete application, know the contents thereof, and declare under penalty of perjury, that all of the information contained herein and evidence of credentials submitted herewith are true and correct and that I am willing to sign a written agreement with a practice setting committing to three or four years of service, corresponding to the source of the subsidy I may be selected for. I authorize representatives of Community First to contact educational institutions I attended and my employers to verify the accuracy of the information contained in this application. I also authorize representatives of Community First 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 Community First New Physician Subsidy Program for which I am applying. I understand that Community First may 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 case, no investigation will be done, and my application for the Community First New Physician Subsidy 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 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 or circumstance that may, if disclosed, affect my application unfavorably. I understand that false information submitted in this application may result in my application not being processed further or, if selected for a subsidy program, my discharge and potential collection action.

I, the undersigned, do, for myself, my heirs, executors and administrators, hereby remise, release, and forever discharge and agree to indemnify Community First 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 Community First) 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 Community First New Physician Subsidy Program.

Signature: _____ Date: _____

Print Name: _____

*Disclosure of Social Security Number (SSN): The Privacy Act of 1974 and collateral federal and state laws and regulations require the informed consent of an individual for the use of that individual's social security number for most purposes, notwithstanding certain exceptions. Community First, a private sector non-profit entity, may request an individual provide her or his SSN for certain purposes, such as identification, verification, credit-reporting, and employment-related reasons. Community First will not make an individual's SSN available for public inspection nor sell the information to any other commercial, non-profit or government entity. Disclosure of an individual's SSN is voluntary, but failure to provide the information may result in denial of the application.

PART F: SPONSORING PHYSICIAN INFORMATION (Sponsoring Physician Only)

The completed form must bear an original ink signature and be returned with the new physician’s application. Photocopies and Faxed copies are not acceptable. The sponsoring physician must prepare a **letter of recommendation** explaining why the new physician would be a good candidate for the Community First New Physician Subsidy Program. The sponsoring physician must also attach a **statement** of how they see their relationship with the new physician playing out during the three or four-year work commitment and beyond.

1. Name of Sponsoring Physician or Practice _____

Address of Practice: _____

Type of Practice: _____

Relationship between Sponsor and New Physician

___ Employee ___ Partner ___ Associate ___ Mentor-Legacy Building

2. Please attach: Medical background including CV, copy of Hawai‘i Medical License, Board Certification (if available) for sponsoring physician.

Sponsoring Physician acknowledges and agrees to the above terms.

Sponsoring Physician Signature: _____ Date: _____

Printed Name: _____ Title: _____

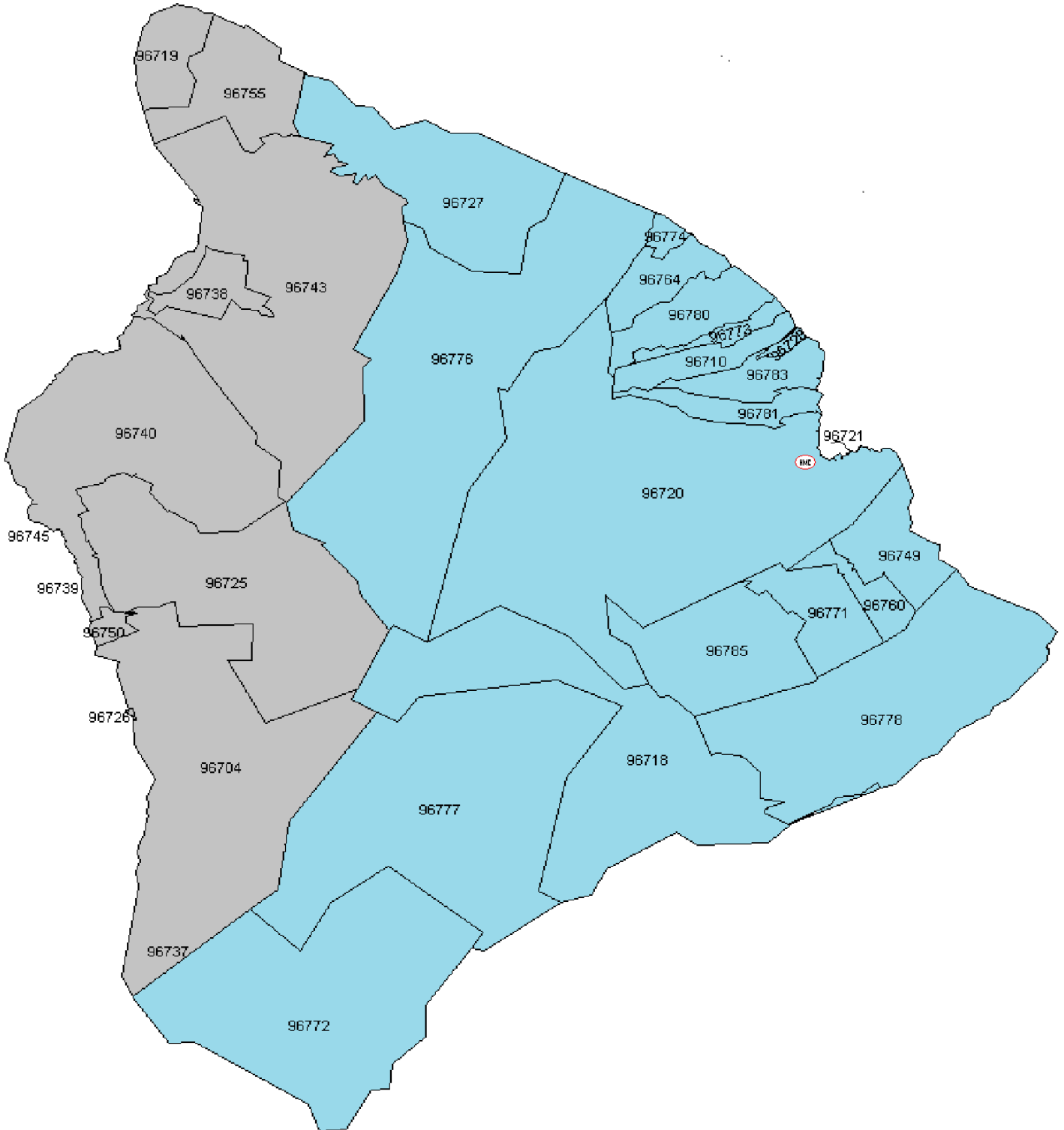
Applicant/New Physician Name: _____

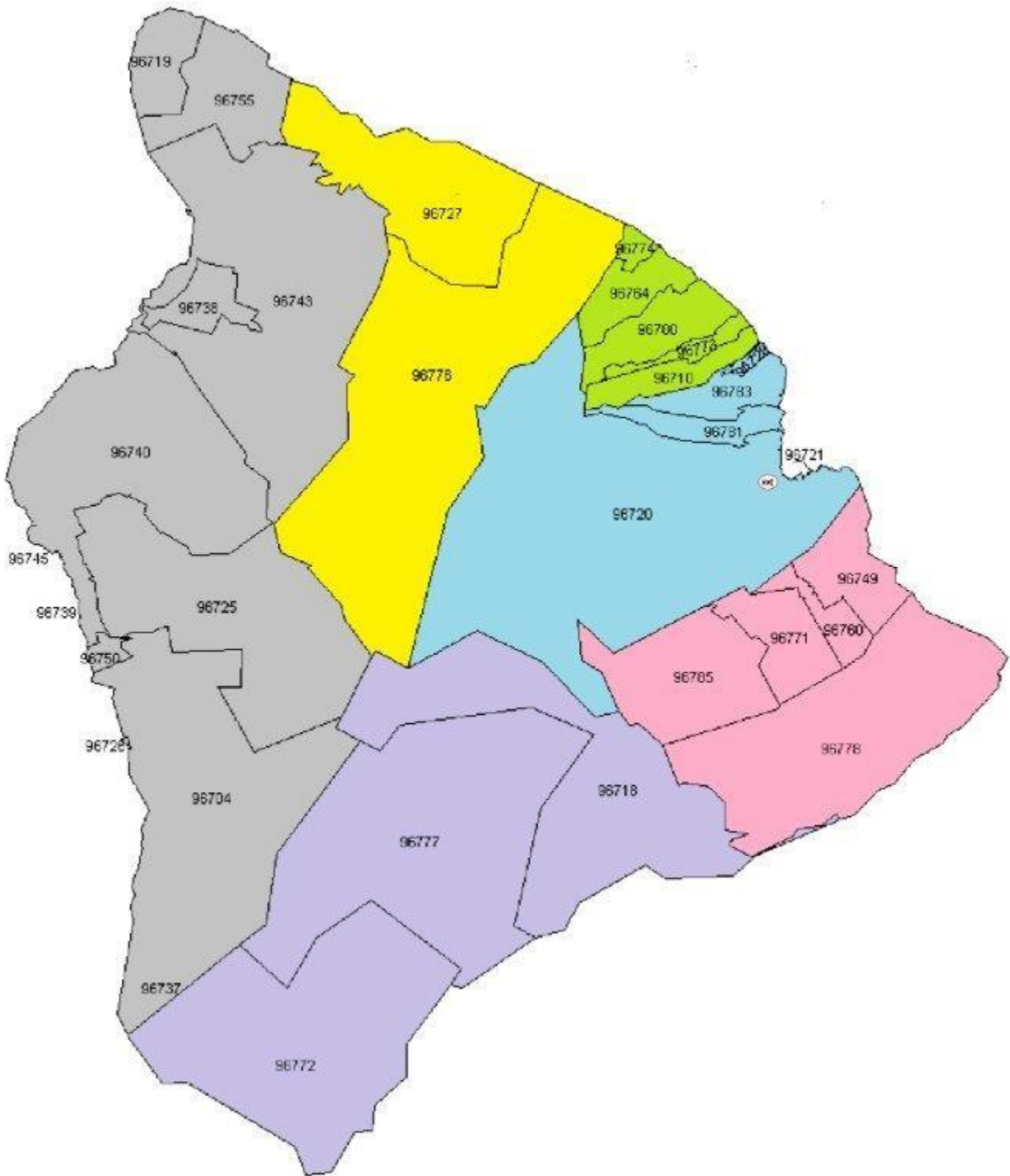
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Application Submission Checklist:

- Completed Application, Parts A – F
- Copy of CV for New Physician, Part B
- Copy of current medical license(s) for the New Physician, Part B
- Copy of current board certification(s) for the New Physician, Part B
- New Physician Personal Statement, Part C
- Letter of Recommendation from Sponsoring Physician, Part F
- Sponsoring Physician Statement, Part F
- Copy of CV for Sponsoring Physician, Part F
- Copy of current medical license(s) for the Sponsoring Physician, Part F
- Copy of current board certification(s) for the Sponsoring Physician, Part F

Appendix A Service Area map







670 Ponahawai Street, Suite 117 | Hilo, Hawaii 96720 | 808-756-9637 Phone | 808-755-9965 Fax
