HBMC Foundation AHEC
HOME RUN Investment Program Application

The HOME RUN Investment Program is supported through the Rural Health Transformation Program (RHTP), funded by the Centers for Medicare & Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling $188,892,439.75, with 100 percent funded by CMS/HHS. The contents of this program and related materials are those of the program administrators and do not necessarily represent the official views of, nor an endorsement by, CMS, HHS, or the U.S. Government.

General Information

The Hawaii Outreach for Medical Education in Rural Under-resourced Neighborhoods (HOME RUN) Investment Program is designed to strengthen Hawaii's rural healthcare workforce by supporting the recruitment, retention, and long-term sustainability of healthcare professionals serving rural and underserved communities throughout the state.

To qualify for a HOME RUN investment award, applicants must be healthcare professionals who are licensed, certified, or otherwise authorized to provide clinical care in Hawaii and who provide, or will provide, direct patient care services to individuals living in rural Hawaii. For purposes of this program, public insurance includes Medicare Fee-for-Service, Medicare Advantage, Medicaid Fee-for-Service, QUEST Integration (Med-QUEST), Veterans Administration, and TRICARE.

Applicants must be United States citizens, lawful permanent residents, or otherwise eligible individuals as permitted by applicable federal and state requirements. Applicants must not be excluded, debarred, suspended, or otherwise disqualified from participation in federal programs and must not have unresolved court-ordered child support obligations or judgments arising from federal debt.

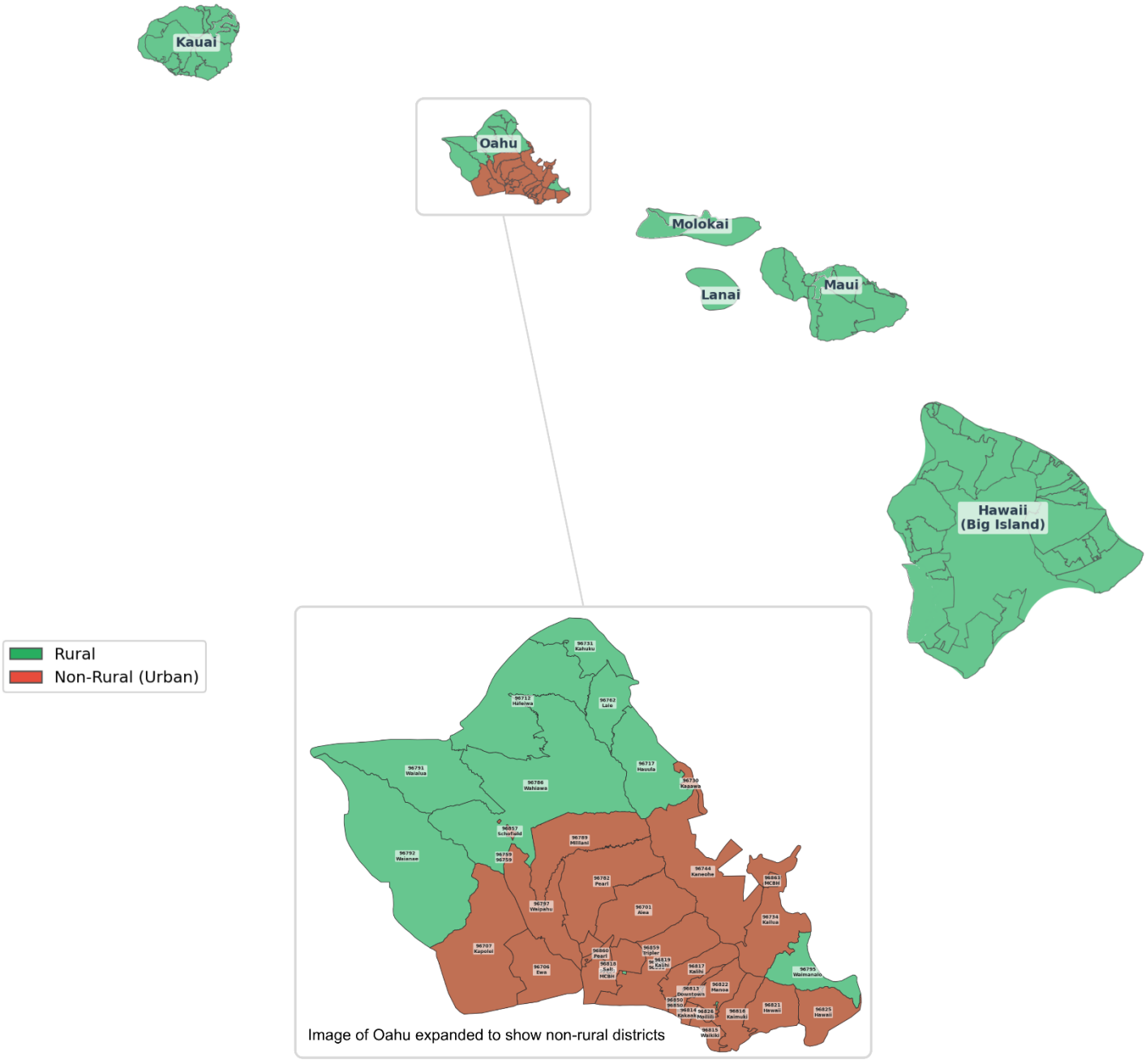
Initial eligibility may include verification of professional licensure, certification, employment status, professional standing, and other information necessary to determine program eligibility.

Award recipients will be selected through a competitive review process conducted by the HOME RUN Investment Committee using approved eligibility criteria and scoring standards.

All applicants selected to participate in the HOME RUN Investment Program must commit to a minimum of five (5) years of full-time clinical service in a qualifying rural Hawaii practice setting. Participants are also encouraged to contribute to healthcare workforce development activities, including student mentoring, teaching, precepting, health career outreach, research, community education, and other workforce pipeline initiatives.

HOME RUN investment payments are awarded directly to the selected participant. Investment payments may be considered taxable income and may be reported to the Internal Revenue Service and applicable State of Hawaii tax authorities on required tax reporting forms, including IRS Form 1099, as required by law. Participants are responsible for consulting their tax advisor regarding any federal, state, or local tax obligations associated with receipt of an investment award.

Map of Hawaii Rural Districts



Instructions for Applying

Contracts will be awarded on a competitive basis. Priority consideration may be given to primary care providers and behavioral health providers working throughout the state, specialists in rural Hawaii, and individuals in residency programs as defined by Hawaii Revised Statutes 1B-1. Priority will also be given to other healthcare providers working in professions and areas for which there is a documented shortage.

Priority consideration may be given based upon:

- Workforce investment category
- Rural workforce shortages
- Healthcare profession or specialty
- Geographic need
- Recruitment or retention impact
- Workforce development contributions
- Availability of program funding

The following documents MUST BE submitted for an application package to be considered complete:

1. Completed Application, including all parts.
2. Copy of current Hawaii professional license or certificate (i.e., for certain technologists).
3. Copy of a valid government-issued identification (such as passport or driver's license)

*An employment start date is required.

Please read the application instructions very carefully. If you have questions regarding the application, application process, or your eligibility for the HOME RUN program, please email us at hbmcfoundation@hhsc.org or call 808-932-3636

Program Awareness

Where did you hear about Hawaii's HOME RUN program?

☐ Work (Employer/Co-worker)
☐ AHEC Website
☐ Other Website (Please list): _____
☐ Family Member, Friend, or Acquaintance
☐ Social Media
☐ Other source (please specify): _____

HOME RUN Workforce Investment Categories

The HOME RUN Investment Program is designed to strengthen Hawaii's rural healthcare workforce by supporting provider recruitment, provider retention, workforce advancement, and practice sustainability. The following categories are intended to guide program priorities and funding discussions.

Please select the workforce investment category that best aligns with the primary purpose of your application. This selection is intended to assist the HOME RUN Investment Committee during the review process. The Committee reserves the right to determine the final workforce investment category for review, scoring, and funding consideration based on the information provided in the application.

For applicants selecting Upskilling, complete the additional section highlighted in the application in lieu of questions that do not apply to your current role.

☐ **Allied Health Professions and/or Upskilling – Up to $40,000 per Individual**
Purpose: Support allied health professionals who play a critical role in rural healthcare delivery and assist healthcare workers/providers pursuing additional education, certification, licensure, or expanded scope of practice to address workforce shortages and improve access to care in rural communities.

☐ **Provider Retention – Up to $50,000 per Individual**
Purpose: Retain experienced healthcare professionals currently serving rural communities and reduce workforce turnover that disrupts patient access and continuity of care.

☐ **Provider Recruitment – Up to $100,000 per Individual**
Purpose: Recruit healthcare professionals to rural Hawaii and attract new talent to communities experiencing workforce shortages.

☐ **Rural Practice Leadership – Up to $200,000 per Individual**
Purpose: Support healthcare professionals whose leadership helps sustain access to care, workforce development, and healthcare infrastructure in rural communities.

HOME RUN investments are intended to support workforce outcomes rather than organizational size. Funding decisions will prioritize the workforce needs of rural communities, the anticipated impact on healthcare access, and the long-term sustainability of Hawaii's healthcare workforce.

For more detailed information on each HOME RUN Workforce investment category please visit: hbmcfoundation.org/homerun

Part A: Personal Information

Last Name		Middle Initial	
First Name		Date of Birth	
SSN		Gender	☐ Male ☐ Female
Mailing Address			
City		Country	
State		Zip Code	
Phone Numbers (Provide at least 2)	( )	☐ Work	☐ Cell/Home
	( )	☐ Work	☐ Cell/Home
Email		☐ Work ☐ School	☐ Personal

Are you a veteran of the U.S. Armed Forces?	☐ Yes ☐ No
Race/Ethnicity: The race/ethnicity information requested 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: _____

List the 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

Professional School where graduated					
School Name				Year of Graduation	
Address					
City		State		Zip Code	
Postgraduate Training				Year Completed/Expected	
Board Eligible	☐ Yes	☐ No		Professional License #	
Board Certified	☐ Yes	☐ No		Certificate #	

Part B: Qualifications and Eligibility

I understand that participating practice sites must currently accept public insurance (Medicare, Medicaid, QUEST Integration, TRICARE, and/or Veterans Administration) for at least 30% of annual patient billing claims, or, for new practices, agree to meet this requirement during the participant's five-year service commitment.	☐ Yes	☐ No

Are you a United States citizen or lawful permanent resident?	☐ Yes	☐ No
Do you have a current unrestricted Hawaii license or state/national certification to practice your profession in Hawaii?	☐ Yes	☐ No
If no, when do you anticipate receiving your Hawaii certification?		
Are you free of judgements arising from Federal debt?	☐ Yes	☐ No
Are you delinquent with any court-ordered child support?	☐ Yes	☐ No

Are you currently participating in or have you applied for other workforce incentive, scholarship, or loan repayment programs?	☐ Yes	☐ No
If yes, what program(s)?		
Do you still have a service commitment for the program(s)?	☐ Yes	☐ No
If yes, how much time do you have left to serve?		

Have you ever received a provider subsidy from another organization in Hawaii?	☐ Yes	☐ No
If yes, what is the name of the organization?		
What was the amount of the subsidy?		
Do you still have a service commitment on the subsidy?	☐ Yes	☐ No
If yes, how much time do you have left to serve?		

Have you received loan repayment funding from the state of Hawaii?	☐ Yes	☐ No
If yes, did you fulfill your service term agreement?	☐ Yes	☐ No
If no, how much time do you have left to serve?		

Part C: Employment Information

Upskilling *(Complete only if applicable)*		
Current credential or profession:		
Credential, degree, certification, or license you are pursuing:		
Educational institution or training program:		
Expected completion date:		
Will you remain employed while completing your education?	☐ Yes	☐ No
If yes, employer:		
Describe how this education or training will improve healthcare access in rural Hawaii.		
Completion of this program will:	☐ Expand your scope of practice ☐ Increase clinical responsibilities ☐ Improve access to care ☐ Help address workforce shortages ☐ Other: _____	
Estimated date you will begin practicing in your new role:		

What is your current health profession? (e.g., APRN, CNA, Dentist, Family Physician, Health IT, Psychologist, RN, etc.)		
Are you employed at a healthcare site?	☐ Yes	☐ No
If yes, please provide the name of the organization and address		
Organization Name		
Organization Address		

Do you own a solo or small practice?	☐ Solo ☐ Small Practice ☐ Part Owner		
Name of practice			
Address of Practice			
Do you pay for your own malpractice?		☐ Yes	☐ No
Do you pay rent for your office space?		☐ Yes	☐ No
Do you need to update or purchase equipment?		☐ Yes	☐ No
Are you planning to open a new healthcare practice?		☐ Yes	☐ No
If yes:	Proposed location		
	Specialty		
	Estimated patient volume		
	Estimated opening date		
	Number of staff positions created		

Do you participate in clinical teaching, precepting or workforce pipeline programs?		☐ Yes	☐ No
If yes, check all activities you are actively participating in.			
☐ Medical student rotations ☐ NP/PA student rotations ☐ Residency training ☐ Mentoring of Providers or healthcare trainees	☐ Health career outreach ☐ AHEC activities ☐ High school mentorship ☐ Other: _____		
During the last 12 months, how many learners have trained in your practice?			
Medical Students		Nursing Students	
Residents		Allied Health	
NP Students		Other:	
PA Students		Please list: _____	
If no, would you be willing to teach students pursuing a career in healthcare?		☐ Yes	☐ No

Which workforce or community activities do you currently participate in?		
☐ School Presentations	☐ Health Screenings	☐ Volunteer Services
☐ Career Fairs	☐ Community Education	☐ Other: _____
☐ Pipeline Programs	☐ Mobile Clinics	

If awarded, describe how you will contribute to developing Hawaii's future healthcare workforce. *Examples include mentoring, precepting, student rotations, health career outreach, AHEC activities, community education, research, or other workforce development activities.*

Do you provide interisland specialty coverage?	☐ Yes	☐ No
Do you have educational debt?	☐ Yes	☐ No
If yes, how much?	$	

Are you in a residency program?	☐ Yes	☐ No
If yes, what is the name of the program?		
What is your expected graduation date?		

Are you in a fellowship program?	☐ Yes	☐ No
If yes, what is the name of your fellowship program?		
What is your expected completion date?		

Do you work full-time (36 hours per week, 45 weeks per year)?	☐ Yes	☐ No
Are you planning to pursue additional training/certifications in the next 12 to 24 months?	☐ Yes	☐ No
Are you currently experiencing recruitment or staffing shortages that limit patient access or service capacity?	☐ Yes	☐ No
If yes, please explain:		

How many hours of direct patient care to patients in rural Hawaii do you perform each week?		
Are you accepting new patients?	☐ Yes	☐ No
Percentage of patient panel that consists of Medicaid, Medicare, TRICARE, or uninsured patients?		
Are you planning to expand services, patient capacity or clinical offerings within the next 1-3 years?	☐ Yes	☐ No
Do you currently serve or plan to serve culturally or linguistically underserved populations?	☐ Yes	☐ No
Do you currently receive or qualify for other workforce support programs (loan repayment, tax credits, etc.)?	☐ Yes	☐ No
Are there provider wellness or burnout concerns that may impact retention?	☐ Yes	☐ No
If yes, please explain:		

Part D: Baseline Workforce & Access Measures

The following questions are intended to establish baseline information about your primary practice site and the rural community it serves. This information will help the HOME RUN Investment Committee evaluate workforce needs and measure program outcomes over time. Unless otherwise indicated, please answer these questions based on your primary practice site or organization. Solo practitioners should respond based on their individual practice.

What is your current panel size? (Practice or Individual, as applicable)	
Number of currently vacant positions at your practice:	
Number of new positions your practice intends to recruit within the next 12 months	
How long have these positions remained vacant?	

If you provide care at multiple locations, please answer the following questions based on the primary practice site where you intend to fulfill your HOME RUN service commitment.

What rural service coverage do you participate in? *Check all that apply:*		
☐ Acute Care/Same Day Care	☐ Disease Management	☐ School/Sports Physical Exams
☐ Birth Control Implants	☐ EKG/PFX	☐ Simple In-Office Procedures
☐ Chronic Diseases	☐ Immunizations	☐ Other: _____
Which counties do you currently provide clinical services in?		☐ Hawaii County ☐ Maui ☐ Kauai ☐ Rural Oahu
Approximately what percentage of your clinical time is spent in each county?		
Please list the primary communities you serve and how many days per week or month in each community. Example: Hana (2 days per week), Kau (3 days per month), Puna (5 days per week), Molokai (1 day per week), North Kohala (5 days per week), etc.		
Approximately how far do your patients typically travel to receive care?		
☐ Less than 10 miles	☐ 10-25 miles	☐ 25-50 miles ☐ Interisland
Approximately how many telehealth visits do you provide each month?		

Approximately how many clinical practice sites do you provide care at?	

Check all that apply:

☐ Clinic	☐ FQHC	☐ Home Visits
☐ Hospice	☐ Long-term care	☐ Palliative Care
☐ Hospital	☐ Mobile Clinic	☐ Other: _____
☐ School	☐ Correctional Facility	

What is the current average wait time for: (Please include days, weeks, months or years)

Routine Primary Care		Urgent Appointment	
Behavioral Health		Specialty Care	
Estimated reduction in wait time if funded:			

Approximately how many hours per week do you spend in each of the following activities?

Activity	Hours	Examples
Direct Patient Care		*Office visits, hospital care, procedures, telehealth, patient documentation directly related to clinical care*
Clinical Administration		*Medical record documentation, prior authorizations, prescription refills, inbox management, disability/FMLA forms, insurance requirements, quality reporting, and other non-clinical administrative tasks*
Practice Leadership & Management		*Medical director duties, supervising staff, budgeting, strategic planning, hiring, committee participation, operational oversight, policy development, and organizational leadership*
Teaching, Mentoring & Workforce Development		*Student rotations, precepting, mentoring, residency education, lectures, AHEC activities, career pathway development*
Community Outreach & Public Health		*Health fairs, community education, school presentations, coalition meetings, advocacy, volunteer clinics, public health initiatives*
Quality Improvement & Patient Safety		*Performance improvement projects, clinical quality initiatives, patient safety activities, workflow redesign, care coordination improvements, accreditation activities, and quality committees*
Research & Scholarship		*Research projects, publications, grant activities, presentations, data analysis, scholarly work*
Other (please specify)		_____

Approximately how many patients each month are unable to obtain an appointment due to provider shortages?	
Estimated number of additional patients served annually if funded:	

In your practice site, department, or community (if known), during the past 3 years:	Practice	Department	Community
How many providers have retired?			
How many providers have left Hawaii?			
How many have been recruited?			
How many vacancies remain?			

What essential services are currently unavailable because of workforce shortages?
Example: OB, Behavioral Health, Dermatology, Dental, Women's Health, etc.

If this investment is awarded, which of the following outcomes do you anticipate? (Check all that apply)

☐ Increased patient access	☐ Recruitment of additional staff	☐ Increased Medicaid capacity
☐ Reduced wait times	☐ Improved provider retention	☐ Increased Medicare capacity
☐ Expanded hours	☐ Expanded student training	☐ Expanded telehealth
☐ Expanded services	☐ Improved financial sustainability	☐ Other: _____

If you were no longer practicing in this community, what would most likely happen to your patients? (Check all that apply)

☐ Patients would likely obtain care locally.
☐ Patients would need to travel to another community.
☐ Patients would likely experience longer wait times.
☐ Services would be reduced until another provider is recruited.
☐ My practice would likely close.
☐ Other: _____

Which single investment would have the greatest impact on your ability to continue serving your rural community? (Please rank them with 1 being the most impactful and 10 being the least impactful)

	Workforce Support		Technology
	Continuing Education		Equipment
	Student Loan or Education Debt		Housing or Relocation Assistance
	Practice Infrastructure		Childcare or Family Support
	Recruitment or Additional Staff		Other: _____

Part E: Ties to Hawaii

Please check all that apply	
☐ Born in Hawaii	☐ Have family in Hawaii
☐ High School in Hawaii	☐ Own a home in Hawaii
☐ College in Hawaii	☐ Teach health professions students in Hawaii
☐ Graduate or Professional education in Hawaii	☐ Currently a resident of Hawaii Since what year: _____
☐ Clinical Training in Hawaii	☐ Other_____

Work(ed) in Hawaii			☐ Yes	☐ No
If yes, when?		How long?		
Perform outreach activities in Hawaii?			☐ Yes	☐ No

If yes, please specify

Describe your connection to rural Hawaii.

What factors would most influence your decision to remain in rural Hawaii long term?

Why is practicing in rural Hawaii important to you?

How will this funding improve healthcare access?

Describe your long-term commitment to rural communities in Hawaii.

Describe barriers/challenges impacting your ability to remain in rural practice.

I understand that I will be required to work in rural Hawaii (defined as County of Hawaii, County of Maui, County of Kauai, Rural Oahu *see map on page 2 of application) for five years from when the funds are received. Participants who fail to complete the required five-year rural service commitment may be required to repay a prorated portion of investment funds received, consistent with HOME RUN program policies, applicable federal guidance, and the terms of the participant agreement.

Signature		Date	

Part F: 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 HOME RUN participation agreement with a practice setting committing to an expected period of time in rural Hawaii of five years of direct patient service on a full-time (36 hours per week, minimum of 45 weeks per yer) basis.

I authorize representatives of the University of Hawaii, including but not limited to representatives from the John A. Burns School of Medicine, Hawaii Pacific Basin Area Health Education Center (UH JABSOM Hawaii Island AHEC and Hilo Benioff Medical Center Foundation), 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 understand that the University of Hawaii/Hilo Benioff Medical Center Foundation 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 HOME RUN Investment 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 my discharge and/or termination from the HOME RUN program.

I understand that if I fail to satisfy the required service commitment, I may be subject to repayment obligations as outlined in the HOME RUN Participation Agreement.

I understand that participants are expected to provide healthcare services consistent with applicable professional standards, evidence-informed practice, and all federal, state, and professional licensing requirements.

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 the HOME RUN Investment Program (collectively the "Released Claims").

I agree to indemnify, defend, and hold harmless the Hilo Benioff Medical Center Foundation and University of Hawaii, and its past, present and future Board of Regent members and University of Hawaii and Hilo Benioff Medical Center Foundation 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 the HOME RUN Investment Program.

Signature		Date	
Print Name			

Part G: Certification of Participating Site

Please report the following information regarding your current workplace:

Applicant's Name			
Workplace Name		City	
Island		Start Date	

Participating Site Information

(This section to be completed and signed by practice site)

The completed form must be returned with the provider's application. Examples of certifiers include the site owner, lead finance officer, or an authorized official of the employer. Electronic signatures are acceptable.

Type of Practice:	☐ FQHC ☐ Employed ☐ Private Group Practice ☐ Private Solo Practice	☐ Locums ☐ Residency ☐ Other: _____
If your main practice site is on Oahu, but you routinely provide care on a neighbor island, please indicate how many days per month, on average, you provide this care:		
Please list the street address of the practice setting(s) where the applicant is working or has entered into an agreement for services		

Primary Practice Site Name			
Address		City	
County		Zip Code +4	
Secondary Practice Site Name			
Address		City	
County		Zip Code +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 of Contact Person	
Telephone Number	
Email Address	
Applicant's start date with primary practice 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 HOME RUN, 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 an investment 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 five-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 Hawaii/Hilo Benioff Medical Center the following:

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

b. Notification by phone to (808) 932-3636, or written notification to hbmcfoundation.org, 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	