OMB Number: 0915-0148
Expiration Date: XX/XX/20XX

Welcome

Last Activity 05/10/2017 03:09:00

Before you begin your 2017-18 NHHSP Application, you need to determine whether or not you are eligible for an Award.

In order to apply for an NHHSP award, you MUST be accepted and enrolled Full-Time in one of the fully-accredited program below no later than September 30, 2017. If you will not be enrolled in one of the degree programs below by Sept 30, 2017, you are not eligible to apply.

- YOU MUST SELECT YOUR SPECIFIC DEGREE FROM THE DROP-DOWN LIST OF 17 ELIGIBLE DEGREES TO APPLY.
- DO NOT LEAVE THIS BLANK
- YOU CAN USE THE -clear- OPTION TO REMOVE YOUR SELECTION

Top of Form

7. Bachelor?s of Science Degree in Nursing - BSN Bachelor?s of Science Degree in Nursing - BSN

Are you of Native Hawaiian Ancestry and able to provide proof and documentation of such (i.e. Original Seal-Embossed Certificate of Birth)?

In accordance with 42 U.S.C. 11711(3), “the term ‘Native Hawaiian’ means any individual who is—

(A) a citizen of the United States, and

(B) a descendant of the aboriginal people, who prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai`i, as evidenced by—

(i) Genealogical records,

(ii) Kupuna (elders) or Kama‘aina (longterm community residents) verification, or

(iii) Birth records of the State of Hawai`i.”

Public Burden Statement: An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0915–0146. Public reporting burden for this collection of information is estimated to average 1.75 hours per response, including the time for reviewing instructions, searching existing data sources, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: HRSA Reports Clearance Officer, 5600 Fishers Lane, Room 14N39, Rockville, MD 20857.

[Type here]

Are you willing to relocate to any island after your education and required licensure to complete the mandatory service obligation component of the NHHSP?

Are you currently under a federally funded scholarship that has a service obligation component to be completed in the future?
Applicants, except military reservists, who are already obligated to a Federal, State or other entity for professional practice or service after academic training are not eligible for Scholarship Program awards. An exception may be made if the obligating entity provides documentation that there is no potential conflict in fulfilling the service commitment to the Scholarship Program and that the Scholarship Program service commitment will be performed first.

Are you delinquent on the repayment of any Federal Debt(s)?
Examples of Federal Debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of direct and guaranteed loans are any loan(s) more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent by the Native Hawaiian Health Scholarship Program.

Are you?

A.) *Already enrolled or accepted as a full-time student in a fully accredited health professions program located in a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Marianas, the U.S. Virgin Islands, the Territory of Guam, the Territory of American Samoa, the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia, and registered or registering for classes beginning no sooner than July 1, 2014, but no later than September 30, 2014. Applicants attending unaccredited schools, on a part time basis, and outside of these geographic areas are not eligible for the Program, although they may be citizens of the United States and of Native Hawaiian ancestry.*

OR

B.) *A new student applying in a fully accredited health professions program located in a State, the District of Columbia, the Commonwealth of Puerto Rico, the Commonwealth of the Northern Marianas, the U.S. Virgin Islands, the Territory of Guam, the Territory of American Samoa, the Republic of Palau, the Republic of the Marshall Islands, and the Federated States of Micronesia, and registering for classes beginning no sooner than July 1, 2014, but no later than September 30, 2014. Applicants attending unaccredited schools, on a part time basis, and outside of these geographic areas are not eligible for the Program, although they may be citizens of the United States and of Native Hawaiian ancestry.*

OR

C.) *Neither of the above.*

[Type here]

APPLICANT PROFILE

Please provide basic information about yourself.
You must submit contact information that will be valid until September 2016.
Required fields are marked with red text and must by filled out.

Degree

7. Bachelor?s of Science Degree in Nursing - BSN Bachelor?s of Science Degree in Nursing - BSN

First Name

Middle Name

Last Name

Maiden Name

Date of Birth

Gender

Select Gender

SSN (last 4 digits)

Home Island

Select Island

Address

City

State

Zip Code

[Type here]

Phone

NEXT

Last Activity 05/10/2017 03:15:00

BACK TO Applicant Profile

EDUCATION INFORMATION

Questions 1-6 must ALL be answered.

Did you apply for the NHHSP scholarship last year ?

1. Have you received an NHHSP Scholarship before?

If "Yes," to no 1 above, what year did you receive your previous NHHSP scholarship?

2. Cumulative GPA to-date (do not include high school GPA):

3. What is the most advanced degree you have obtained?

When was this degree earned?

4. Have you received a letter of acceptance to the program of study for which you are seeking an NHHSP award?

If "Yes," what is the date that you received your letter of acceptance? If "No," what is the latest date you expect to be notified of your acceptance into your program(s)?

5. Which program of study are you applying to, or enrolled in? In order to be eligible for an NHHSP award, you must be enrolled in one of the programs below no later than September 30, 2017:

7. Bachelor?s of Science Degree in Nursing - BSN Bachelor?s of Science Degree in Nursing - BSN

6. If you are applying to your program of study this year, how many colleges did you apply to? If you are already accepted into your program of study, select "Accepted."

Questions 7-16 must ALL be answered.

7. First Choice College - Name of Institution you are enrolled in, or applying to:

If your college is not among the commonly selected colleges in the dropdown menu, please type in your response.

8. First Choice College - Is your School/College and program primarily online?

9. First Choice College - Name of specific School/College and Program you are enrolled in, or applying to:

e.g. The John A Burns School of Medicine, or the Daniel K. Inouye College of Pharmacy.

10a. First Choice College - College Program Street Address:

10b. First Choice College - College Program City:

10d. First Choice College - College Program State:

10d. First Choice College - College Program Zip:

11. First Choice College - College/University and Program Advisor - Contact Person (name):

Indicate the person's name and title. If uncertain at this time, please indicate "Uncertain."

12. First Choice College - College/University and Program Advisor - Contact Person's Phone # (ex: 808-123-1234 x567):
13. First Choice College - Is the School/College and Program you've selected ACCREDITED?
It is mandatory that NHHSP scholars attend ACCREDITED Schools/Colleges and Programs that are congruent with national healthcare professional standards and ethics established by such organizations as the American Medical Association (AMA), the National Association of Social Workers (NASW), American Dental Association (ADA), etc.
14. First Choice College - Are you eligible for In-State tuition at this College/University?
15. Based on your desired degree and course curriculum, indicate the approximate date you started or will start your First Choice College program:
16. When is your projected graduation date for your First Choice College program?

Questions 17-32 are ALL optional.

17. Second Choice College - Name of Institution you are enrolled in, or applying to:
If your college is not among the commonly selected colleges in the dropdown menu, please type in your response.
18. Second Choice College - Is your School/College and program primarily online?
19. Second Choice College - Name of specific School/College and Program you are enrolled in, or applying to:
e.g. The John A Burns School of Medicine, or the Daniel K. Inouye College of Pharmacy.
20a. Second Choice College - College Program Street Address:
20b. Second Choice College - College Program City:
20c. Second Choice College - College Program State:
20d. Second Choice College - College Program Zip:
21. Second Choice College - College/University and Program Advisor - Contact Person (name):
Indicate the person's name and title. If uncertain at this time, please indicate "Uncertain."
22. Second Choice College - College/University and Program Advisor - Contact Person's Phone # (ex: 808-123-1234 x567):
23. Second Choice College - Is the School/College and Program you've selected ACCREDITED?
It is mandatory that NHHSP scholars attend ACCREDITED Schools/Colleges and Programs that are congruent with national healthcare professional standards and ethics established by such organizations as the American Medical Association (AMA), the National Association of Social Workers (NASW), American Dental Association (ADA), etc.
24. Second Choice College - Are you eligible for In-State tuition at this College/University?
25. Third Choice College - Name of Institution you are enrolled in, or applying to:
If your college is not among the commonly selected colleges in the dropdown menu, please type in your response.
26. 3rd Choice College - Is your School/College and program primarily online?
27. Third Choice College - Name of specific School/College and Program you are enrolled in, or applying to:
e.g. The John A Burns School of Medicine, or the Daniel K. Inouye College of Pharmacy.
28a. Third Choice College - College Program Street Address:
28b. Third Choice College - College Program City:
28c. Third Choice College - College Program State:
28d. Third Choice College - College Program Zip:
29. 3rd Choice College - College/University and Program Advisor - Contact Person (name):

Indicate the person's name and title. If uncertain at this time, please indicate "Uncertain."

30. Third Choice College - College/University and Program Advisor - Contact Person's Phone # (ex: 808-123-1234 x567):

31. Third Choice College - Is the School/College and Program you've selected ACCREDITED?

It is mandatory that NHHSP scholars attend ACCREDITED Schools/Colleges and Programs that are congruent with national healthcare professional standards and ethics established by such organizations as the American Medical Association (AMA), the National Association of Social Workers (NASW), American Dental Association (ADA), etc.

32. 3rd Choice College - Are you eligible for In-State tuition at this College/University?

33. Have you received a "Verification of Disadvantaged Background Status" from your School/College's financial aid office?

If "Yes," prepare to submit the documents to NHHSP.

CRITERIA FOR DISADVANTAGED BACKGROUND STATUS: - Come from an environment that has inhibited them from obtaining the knowledge, skills, and abilities required to enroll in and graduate from a health professions or nursing school (Environmentally Disadvantaged). The following are provided as examples of "Environmentally Disadvantages" for guidance only and are not intended to be all-inclusive. Examples: - Person from high school with low average SAT/ACT scores or below the average State test results. - Person from a school district where 50 percent or less of graduates go to college. - Person who has a diagnosed physical or mental impairment that substantially limits participation in educational experiences. - Person for who English is not his or her primary language and for whom language is still a barrier to academic performance. - Person who is first generation to attend college. - Person from a high school where at least 30 percent of enrolled students are eligible for free or reduced price lunches. – OR – - Come from a family with an annual income below a level based on low-income thresholds established by the U.S. Census Bureau, adjusted annually for changes in the Consumer Price Index (Economically Disadvantaged). - The Secretary defines a ''low income family'' for various health professions and nursing programs included in Titles III, VII and VIII of the Public Health Service Act as having an annual income that does not exceed 200 percent of the Department's poverty guidelines. A family is a group of two or more individuals related by birth, marriage, or adoption who live together or an individual who is not living with any relatives. For information about programs for disadvantaged students, visit the Web site: http://www.hrsa.gov/loanscholarships/index.html and access the required form through the following link: http://nhsc.hrsa.gov/downloads/disadvantagedbackground.pdf.

DOCUMENT DOWNLOAD & SUBMITTAL

You must download, fill out, and submit the following documents via this Application Portal. Click the download buttons to download each document below. You can drag and drop your completed documents into the fields below to submit them. All documents submitted to the NHHSP must be in PDF format.

IT IS HIGHLY RECOMMENDED THAT YOU DOWNLOAD THE LATEST VERSION OF ADOBE ACROBAT READER TO COMPLETE THESE FORMS. ACROBAT READER IS A FREE DOWNLOAD AT ADOBE.COM. Before clicking Install Now, uncheck McAfee Security Scan Plus and True Key by Intel Security. That's extra software you probably don't want.

Application Process & Instructions 2017-18.pdf (Instructions Only: Does not require re-upload via this website)

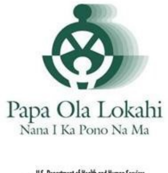
Application Packet A 2017-2018.pdf (Does not require re-upload via this website)

Application Packet B 2017-2018.pdf (Does not require re-upload via this website)

Download Blank Form	Select Completed Form	Upload	Delete	Status	View
FORM A Conflict		UPLOAD FORM A			—
FORM B Certification		UPLOAD FORM B			—
FORM C Debt		UPLOAD FORM C			—
FORM D Authorization		UPLOAD FORM D			—
FORM E Curriculum		UPLOAD FORM E			—
RESUME		UPLOAD RESUME			—
ESSAY		UPLOAD ESSAY			—

[Type here]

Applicant Headshot Photo		UPLOAD HEADSHOT



NHHSP 2017-2018 Application Process & Instructions

Online Application Opens: December 1, 2016

www.nhhsp.org

Closes: March 1, 2017, 11:59pm HST

The NHHSP Application Process includes the following Steps:

(I) Preparing for Online Application:

Download and review the NHHSP 2017-2018 Application & Program Guidance (APG) and gather all of the required information you will need to file your NHHSP Online Application as indicated below:

Besides basic identifying information, the applicant will need to gather the following and have them available while online to complete the Application:

- The name of the PROGRAM you are attending or applying to, and the specific name of the UNIVERSITY and CAMPUS (e.g. University of Hawai`i School of Nursing and Dental Hygiene at Manoa). Applicants who are applying to multiple Universities will list their top 3 choices.
- The address for the Program/University(s).
- The name and phone number of a Contact Person/Advisor at the Program/ University(s).
- If you are applying for an NHHSP award while also applying for your program of study, you must submit proof of your college/program acceptance, and begin instruction/ classes/ coursework no later than September 30, 2017. YOU ARE NOT ELIGIBLE FOR AN AWARD if you are scheduled to begin your program of study any time after September 30, 2017
- The cumulative GPA on the most recent college transcripts. (Do not include high school GPA).
- The timeline associated with the curriculum of the proposed Program (i.e. Program start and graduation dates based on an official course curriculum and schedule).
- A mailing address; last 4 digits of the applicant's Social Security Number, applicant's home island; area code & phone number; eMail address; and other contact information (all information requested here must be valid through September 30, 2017).

(II) Online NHHSP Application Portal Registration, Eligibility Screening, Applicant Profile and Downloadable Application Forms & Instructions:

The applicant will logon to **http://www.nhhsp.org**, then select the **APPLY** tab to **create** a username & password (**your eMail address is required** for use as **your username,** and will remain current throughout the entire application process). Follow the online instructions and complete the following:

1) **Eligibility Screening** – Answer all program eligibility questions as instructed;

2) **Applicant Profile** - Answer all profile questions as instructed;

3) Download all **Application Forms & Instructions** – Follow the instructions carefully.

The following documents will be submitted by MAIL OR eMAIL:

1) **Proof of Hawaiian Ancestry.** The applicants' **original seal-embossed certificate of birth** will be POSTMARKED and MAILED to NHHSP no later than **March 1, 2017** to:
NHHSP Operations Coordinator, 894 Queen Street, Honolulu, Hawai`i 96813

2) **<u>All Past and Current Official College Transcripts</u>** requested by the applicant, will be mailed <u>directly</u> to: NHHSP Operations Coordinator, 894 Queen Street, Honolulu, Hawai`i 96813, or emailed to adminassist@nhhsp.org by the respective college, no later than **March 1, 2017**

3) **College Acceptance Letter/ Proof of Application**: If you plan to begin your program in the Fall of 2017 (but no later than September 30, 2017), and awaiting your acceptance letter, then you must submit all correspondence from your college regarding your application (e.g. letters of conditional acceptance pending the completion of a prerequisite course, etc.). **The deadline to submit your College Letter of Acceptance is May 1, 2017 at 11:59pm HST**.

4) Verification of Disadvantaged Background: **FASFA Student Aid Report (SAR) on Expected Family Contribution (EFC)** must be requested by the applicant and eMailed to NHHSP by **March 1, 2017 11:59pm HST** adminassist@nhhsp.org.

5) **(a.)** College **Academic Faculty/Advisor Evaluation Form (mandatory); and either (b.) EMPLOYER Evaluation Form or (c.) COMMUNITY RESOURCE/Personal Reference Evaluation Form** will be **completed by the designated evaluator who will either MAIL or eMAIL** the completed forms **directly** to NHHSP no later than **March 1, 2017 @ 11:59pm**.

NHHSP Operations Coordinator
894 Queen Street, Honolulu, Hawai`i 96813
or to adminassist@nhhsp.org

Note: A MINIMUM OF TWO EVALUATIONS WILL BE SUBMITTED TO NHHSP. The College **Academic Faculty/Advisor Evaluation Form is mandatory.** The second evaluation may be the **Employer Evaluation Form** or the **Community Resource/Personal Reference Evaluation Form**.

To submit your application forms and documents, logon to http://www.nhhsp.org with the user name (your eMail address) and password you created and follow the instructions.

Submit the following completed documentation through the appropriate portal:

- Applicant Resume or Curriculum Vitae
- Applicant Narrative Statements in Response to the NHHSP Questions
- *Form A*: Memorandum Regarding Conflicting Federal Service Obligations
- *Form B*: Certification Regarding Debarment, Suspension, and Disqualification
- *Form C*: Delinquent Federal Debt
- *Form D*: Authorization to Release Information
- *Form E*: Program Course Curriculum

NHHSP will contact you to schedule an interview,

[Type here]

U.S. Department of Health and Human Services
HEALTH RESOURSES & SERVICES ADMINISTRATION
PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

NHHSP 2017-2018 Application Process Checklist

APPLICANT'S' NAME	CONTACT NUMBER	eMAIL ADDRESS

APPLICATION PROCESS, CHECKLIST, DOCUMENTS & FORMS: Date Completed:

Part I: Download & Review the 2017-2018 APG ________________

Print Application Document Checklist

Part II: Prepare Information for Online ________________

Application Part III: Apply at www.nhhsp.org ________________

Complete and Submit the following Application Documents:

Packet A

Proof of Native Hawaiian Ancestry ________________

College Transcripts ________________

College Letter of Acceptance ________________

FAFSA StudentAid Report ________________

Packet B

#1: Academic Faculty / Advisor Evaluation Form (sent to Evaluator on:) ________________

#2: Employer Evaluation Form (sent to Evaluator on:) ________________

#3: Community/Personal Evaluation Form (sent to Evaluator on:) ________________

Section C

Applicant Resume / Curriculum Vitae ________________

NHHSP Questionnaire & Applicant Narrative Statements ________________

(ESSAY) *Form A- Memorandum RE: Federal Conflicting* ________________

Service Obligations Form B - Certification Regarding ________________

Debarment, Suspension.....

Form C - Certification Regarding ________________

Federal Debt Form D - Authorization ________________

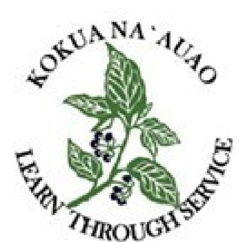
to Release Information Form E- ________________

Program Course Curriculum

All required original hardcopy documents **will be postmarked and mailed no later than March 1, 2017** to: NHHSP

Operations Coordinator

894 Queen Street,
Honolulu, Hawaii 96813



PROOF OF NATIVE HAWAIIAN ANCESTRY

Instructions

Applicants are required to submit proof of Native Hawaiian Ancestry.

In accordance with 42 U.S.C. 11711(3), "the term 'Native Hawaiian" means any individual who is

(A) a citizen of the United States, and

(B) a descendant of the aboriginal people, who prior to 1778, occupied and exercised sovereignty in the area that now constitutes the State of Hawai`i, as evidenced by—

(i) Genealogical records,

(ii) Kūpuna (elders) or Kamaʻaina (long-term community residents) verification,

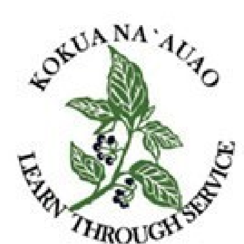
or (iii) Birth records of the State of Hawai`i."

Applicants will submit an original (with embossed seal) certificate of birth that verifies Native Hawaiian ancestry. If Hawaiian ancestry is not listed, the Applicant will enclose an original (with embossed seal) certificate of birth, of the Applicants' Native Hawaiian parent, along with Applicants' birth certificate. Those with names not matching the original certificate of birth will submit copies of documents (marriage certificate / legal name change) demonstrating such name change.
Certificates of Birth will be submitted along with other pertinent documents identified in the Application Document Checklist.

All birth certificates mailed to NHHSP will be returned to the Applicant after the close of the Application season.

Mail required documents to:

Native Hawaiian Health Scholarship Program
ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813



COLLEGE TRANSCRIPTS
Instructions

Applicants must request their official College Transcripts from ALL previous and current College institutions, and have the College send them directly to:

Native Hawaiian Health Scholarship

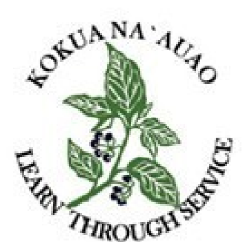
Program 894 Queen St, Honolulu, HI

96813

If your college offers digital copies of your official transcript, you may have them send the download link of your transcript documents to:

adminassist@nhhsp.org

NHHSP will not accept digital copies of official transcripts that are submitted via email from the applicant themselves. All digital Official Transcripts must come directly from applicants' educational institution via a download link or from official .edu email addresses ONLY.



COLLEGE ACCEPTANCE LETTER/PROOF OF APPLICATION

Instructions

To be eligible for a 2017-2018 NHHSP award, Applicants are required to enroll in a fully accredited health profession degree program as a full-time student. Applicants must begin their course work by **September 30, 2017.**

NOTE: Ensure that program prerequisites are completed.

For NHHSP Application Year 2017-2018, submit a copy of your College Acceptance Letter by **MARCH 1, 2017**

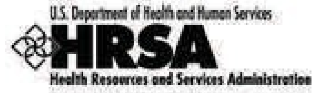
If your program begins in the Fall of 2017 and your college acceptance letter is not received by March 1, 2017, submit all correspondence from your college regarding your application (e.g. letter of conditional acceptance pending the completion of a prerequisite course, etc.).

The deadline to submit your Official College Acceptance Letter is Friday, May 1, 2017 at 4PM HST.

If you have any questions, contact the NHHSP Operations Coordinator

at (808) 597-6550 ext. 203 or adminassist@nhhsp.org

Mail your documents to: Native Hawaiian Health Scholarship Program
ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813



FREE APPLICATION for FEDERAL STUDENT AID (FAFSA) Instructions

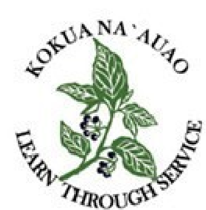
Go to **https://fafsa.gov/** to request your FAFSA report.

The 2017 FAFSA must be filed by the Applicant AFTER January 1, 2017, which will generate the Expected Family Contribution (EFC) report. The **EFC** must be eMailed to NHHSP **no later than March 1, 2016 at 11:59PM.**

Indicate your name in the Subject of your e-mail message, and include your last name in your FAFSA PDF's filename (e.g. "YOURLASTNAME_2016FAFSA.PDF').

E-mail your FAFSA SAR to NHHSP at:

adminassist@nhhsp.org



ACADEMIC FACULTY/ADVISOR EVALUATION FORM
Instructions

Applicant:
Mail or e-Mail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated ACADEMIC evaluator has received, completed, signed and mailed their evaluation directly to NHHSP.

NOTE: The Academic Faculty/Advisor Evaluation form is MANDATORY.

Evaluator:
Complete and mail the attached form directly to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THE ATTACHED FORM MUST BE MAILED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions, contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203 or adminassist@nhhsp.org

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

APPLICANT'S NAME	eMAIL ADDRESS	PHONE: ☐ CELL ☐ HOME
COLLEGE / UNIVERSITY		PROJECTED Graduation MO/YR

The student/NHHSP Applicant, identified above, is applying for a Scholarship with the Native Hawaiian Health Scholarship Program (NHHSP). The requested information is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on academic faculty/advisor recommendation when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the U. S. Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register.*

Return this completed & signed 'ACADEMIC EVALUATION' Form #1 to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

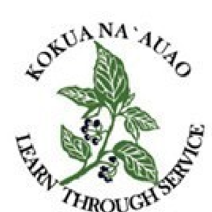
Comments:______________________________

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others. 5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:______________________________

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

NAME (Print or type)	
POSITION TITLE (Required)	PLACE OF EMPLOYMENT (Required)
SIGNATURE	DATE



EMPLOYER EVALUATION FORM
Instructions

Applicant:
Mail or eMail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated EMPLOYER evaluator has received, completed, signed and mailed the evaluation form directly to NHHSP.

NOTE:
If you are currently **unemployed**, a Community Resource/Personal Reference Evaluation form may be completed and submitted in lieu of an Employer Evaluation form.

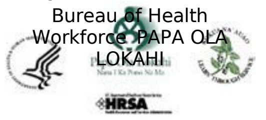
Evaluator:
Complete and mail the attached form directly to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THIS FORM MUST BE SUBMITTED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions, contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203 or adminassist@nhhsp.org

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health Workforce PAPA OLA LOKAHI



Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

NHHSP APPLICANT'S NAME APPLICANT'S place of Employment	eMAIL ADDRESS PHONE: ☐ CELL ☐ HOME

The NHHSP Applicant, identified above, is applying to receive a Native Hawaiian Health Scholarship Program (NHHSP) scholarship. The information on this form is requested pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on employer recommendation, when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the U. S. Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register.*

Return this completed & signed 'EMPLOYER EVALUATION' Form #2 directly to NHHSP

1. How do you rate the educational and/or work achievement of this Applicant?

____

____

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others. 5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

____

____

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

____

____

4. Relationship to NHHSP Applicant:____

5. Length of time known: ____

***If more space is required, use additional sheets of 8.5x11" paper. Write your name and social security number on each additional sheet of paper/ Securely attach additional sheets to this form*

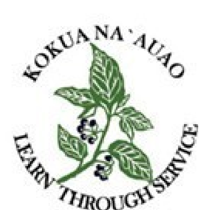
Statement of Conflict of Interest: I certify I am not related to NHHSP Applicant by blood or marriage.

I certify that the information provided in this evaluation is accurate. I understand that it may be investigated and that any willfully false representation is sufficient for rejection of this application.

NAME (Print or type)

POSITION TITLE (Required)	PLACE of EMPLOYMENT (Required)

SIGNATURE DATE



COMMUNITY RESOURCE / PERSONAL REFERENCE EVALUATION FORM
Instructions

Applicant:
Print and mail or eMail the attached evaluation form, along with this instruction page to your evaluator.

Ensure that your designated COMMUNITY RESOURCE/PERSONAL REFERENCE evaluator has received, completed, signed and mailed their evaluation directly to NHHSP.

Evaluator:
Complete and mail the attached form **directly** to:

Native Hawaiian Health Scholarship Program ATTN: NHHSP Operations Coordinator
894 Queen Street
Honolulu, HI 96813

REMINDER: THIS FORM MUST BE SUBMITTED TO NHHSP NO LATER THAN MARCH 1, 2017.

If you have any questions contact the NHHSP Operations Coordinator at (808) 597-6550 ext. 203

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

NHHSP APPLICANT'S NAME	eMAIL ADDRESS
APPLICANT'S relationship to Evaluator	PHONE: ☐ CELL ☐ HOME

The NHHSP Applicant, identified above, is applying to receive a Native Hawaiian Health Scholarship Program (NHHSP) scholarship. The requested information on this form is pursuant to Section 751-756 of the Public Health Service Act, and the applicable program regulations which provide for consideration be given, based on community resource or personal reference recommendation, when evaluating and selecting individuals for scholarships.

The information provided on this form is treated as confidential and may only be disclosed outside the Department of Health and Human Services in accordance with provisions of the Privacy Act of 1974 (P.L. 93-579) and the terms and conditions of the applicable Privacy Act Notice published by the Department in the *Federal Register*.

Return this completed & signed 'COMMUNITY RESOURCE/PERSONAL REFERENCE' Form #3 **directly** to NHHSP.

1. How do you rate the educational and/or work achievement of this Applicant?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

2. How do you rate the Applicant's relationships with other people? Consider such things as ability to work and get along with others. 5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

3. Based on this Applicant's personal, emotional, and ethical attributes, how do you rate his/her overall potential for the practice of primary health care, especially in a Health Provider Shortage Area (HPSA)?

5 - ☐ OUTSTANDING 4 - ☐ ABOVE AVERAGE 3 - ☐ AVERAGE 2 - ☐ BELOW AVERAGE 1 - ☐ POOR

Comments:____

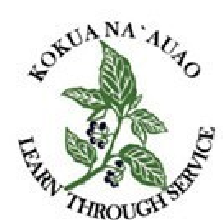
4. Applicant's role/job at Community Agency:
5. Length of time known: ______________________________

***If more space is required, use additional sheets of 8.5x11" paper. Write your name and social security number on each additional sheet of paper/ Securely attach additional sheets to this form*

Statement of Conflict of Interest: I certify I am not related to the NHHSP Applicant by blood or marriage.

NAME (Print or type)	
Position Title (at Community Agency)	ame of Community Agency
SIGNATURE	DATE

N



Form A - MEMORANDUM REGARDING CONFLICTING FEDERAL SERVICE OBLIGATIONS

To: Native Hawaiian Health Scholarship Program

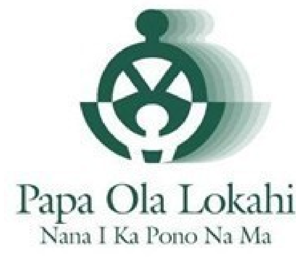
From: ______________________________
Print Name

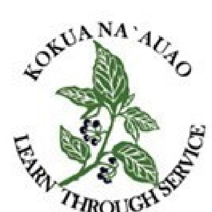
Subject: Conflicting Service Obligations

I, ______________________________, certify that I have **no** conflicting service obligations that would cause a breach of contract with the Native Hawaiian Health Scholarship Program.

____

NHHSP Applicant Signature Date





Form B - CERTIFICATION REGARDING DEBARMENT, SUSPENSION, DISQUALIFICATION and RELATED MATTERS

Pursuant to 2 CFR 180.335 (2006) as implemented by 2 CFR 376.10 (2007), an Applicant applying to enter into a covered transaction (which includes an application to participate in the Native Hawaiian Health Scholarship Program) is required to notify the Federal agency office if the Applicant knows that he or she:

- Is presently debarred, suspended, excluded, or disqualified from participation in covered transactions by any Federal agency or department;
- Within the 3-year period preceding the application, has been convicted of, or had a civil judgment ren- dered against him or her for any of the following offenses:
    - ◊ commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, and/or performing a public (Federal, State, or local) transaction or a contract under a public transaction;
    - ◊ violation of Federal or State antitrust statutes; and/or
    - ◊ commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, and/or obstruction of justice;
- Is presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with the commission of any of the offenses set forth above; or
- Within a 3-year period preceding the application, has had any public transaction (Federal, State, or local) terminated for cause or default.

The 2017-2018 NHHSP Applicant will sign the certification below where applicable to his/her situation.

☐ I certify that **none** of the above statements apply to me.

OR

☐ I certify that **one or more** of the above statements apply to me.

____

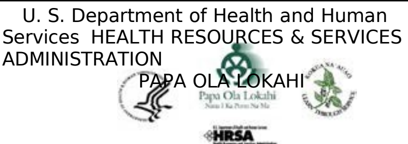
PRINT name

____

NHHSP Applicant Signature Date

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION

PAPA OLA LOKAHI



Title 42 USC Chapter 122 Section 11709– Native Hawaiian Health Scholarship Program

Form C - DELINQUENT FEDERAL DEBT

APPLICANTS' NAME	LAST **4**-DIGITS of SSN
eMAIL ADDRESS	PHONE: ☐ CELL ☐ HOME

INSTRUCTIONS:

Applicants are required to include this completed form along with their application, and other supporting documentation. Check the appropriate box below. If the "Yes" box is selected, provide an explanation in the space provided.

Examples of Federal Debt include delinquent taxes, audit disallowances, guaranteed or direct student loans, FHA loans, and other miscellaneous administrative debts. The definition of delinquency for the purposes of guaranteed or student loans are any loans more than 31 days past due on a scheduled payment. Deferred loans are not considered delinquent by the Native Hawaiian Health Scholarship Program.

ARE YOU DELINQUENT ON THE REPAYMENT OF ANY FEDERAL DEBT(S)? ☐ **Yes** ☐ **No**

If your response is "Yes," provide an explanation in the space provided below. Include the name of the Federal Agency (to which debt is owed), type (student loan, HUD Mortgage, etc.), telephone number and name of contact person handling the debt, include the account number if different from your SSN. **You are required to provide a notarized power of attorney, in some cases the Federal Agency may require you to use their power of attorney document, authorizing the release of information to the NHHSP Division of Grants Operations to inquire about your debt. If authorization is not included, your application will not be considered for an award.**

Federal Agency	Type of Loan	Account #	Contact Name	Phone #

I

I certify that the information given on this application is accurate and complete to the best of my knowledge and belief. I

NHHSP APPLICANT SIGNATURE	DATE

Sample Power of Attorney:

I,_______________________________________of____
[print student's name] [insert address]

hereby authorize the Native Hawaiian Health Scholarship Program ________________________
[insert address of organization-in-fact]

to inquire on my debt to the___________________________, for my benefit to remain eligible as
[insert organization]

an NHHSP scholarship applicant.

This **Power of Attorney** is granted for a period of one year and shall become effective on ______________
[date]

and shall terminate on____________.
[date]

Specified Date

Executed this________day of __________, 20____ at ____________.
[day] [month] [year] [time]

______________________________________ ______________________________________
[print name] [signature]

Notary Acknowledgement

State of _____________________________; County of _______________________________.

On this the ___________ day of _____________, 20____, before me___________________,
[day] [month] [year] [insert name of notary]

the undersigned officer, personally appeared_________________________________,
[print student's name]

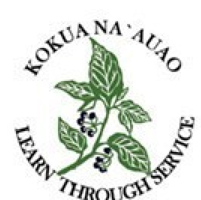
known to me or proven satisfactorily to be the person whose name is subscribed to the within instrument, and acknowledge that he or she executed the same for the purposes therein contained.

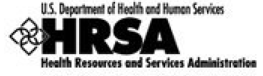
In witness whereof, I hereunto set my name and official seal.

____
[signature of notary]

My Commission Expires: [insert official seal]

SAMPLE





Form D - AUTHORIZATION TO RELEASE INFORMATION

As an applicant to the Native Hawaiian Health Scholarship Program

(NHHSP), I, (print) ______________________________ First Name Middle Initial

Last Name

hereby authorize the College/University where I am/was enrolled, to disclose information to NHHSP, Papa Ola Lokahi, Inc. (POL) and the U.S. Department of Health and Human Services (DHHS), pertaining to my enrollment while participating in NHHSP. "Information pertaining to my school enrollment" includes, but not limited to, my college transcript and grades, academic standing, enrollment and degree status, curriculum and examination requirements for graduation, tuition and fees, and leave-of-absence, withdrawal, or dismissal from school.

If I become a participant in the NHHSP, I also authorize any post-degree training program for which I received a deferment from the NHHSP to disclose to POL and DHHS information pertaining to my participation in the post-degree program including, but not limited to, my curriculum, status in the program, completion date, examination requirements, and my leave- of-absence, withdrawal or dismissal from the program.

The above authorizations take effect on the date indicated below with my signature.

In addition, I hereby authorize POL and DHHS, to release my name, addresses and social security number to see if I appear on the Excluded Parties List System. This authorization takes effect on the date I sign this release form. If I do not become an NHHSP participant, this **authorization shall remain in effect until November 30, 2017.**

If I become an NHHSP participant, all of the above authorizations shall remain in effect until the date my NHHSP scholarship commitment has been fulfilled or these authorizations have been revoked by me in writing.

____

Applicants' Signature Date

U. S. Department of Health and Human Services HEALTH RESOURCES & SERVICES ADMINISTRATION
Bureau of Health Workforce PAPA OLA LOKAHI

Title 42 Chapter 122 Section 11709 Native Hawaiian Health Scholarship Program

APPLICANT'S NAME	DEGREE ie. Masters Degree in Nursing
COLLEGE / UNIVERSITY	PROJECTED GRADUATION MO/YR

THIS *Form E* - Program Course Curriculum MUST BE COMPLETED and RETURNED to NHHSP

APPLICANT applied for Admission or is Enrolled at above-mentioned College/University since/for the **Academic Year 20____- 20__**. APPLICANT will be enrolled OR is anticipated to be enrolled **Full-Time** in an undergraduate/graduate degree-seeking program (identified above) for the Academic Year **2017-2018**.

LIST Degree Program CURRICULUM from (start of) FIRST YEAR to COMPLETION

e.g. FALL 2017 Months: August-December

SUMMER ___________(Year) **Months:______________ ____________** ***YEAR ONE***

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SIGNATURE	DATE

SPRING_______________(Year) **Months:_________________ ______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SUMMER _____________(Year) **Months:_________________** ***YEAR TWO***

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

FALL_______________(Year) **Months:_________________ ______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SPRING_______________(Year) **Months:_________________ ______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

APPLICANT: ____

SUMMER ______________(Year) **Months:__________________** ***YEAR THREE***

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

FALL_______________(Year) **Months:______________________________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SPRING_______________(Year) **Months:______________________________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SUMMER ______________(Year) **Months:__________________** ***YEAR FOUR***

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

APPLICANT:____

FALL_______________(Year) **Months:_______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

SPRING_______________(Year) **Months:_______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

_______________(Year) **Months:_______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

_______________(Year) **Months:_______________**

COURSE NUMBER	CREDIT HOURS	COURSE TITLE

APPLICANT: _______________