New Jersey Department of Health

**Office of Policy and Strategic Planning**

**369 S. Warrant Street, 8th Floor**

**PO Box 360**

**Trenton, NJ 08625-0360**

**J-1 VISA WAIVER / STATE CONRAD 30 PROGRAM: PHYSICIAN-PRIMARY CARE SURVEY**

# INITIAL/BIANNUAL SERVICE REPORT

|  |
| --- |
| 1. Name of Agency |
| 2. Address |
| 3. Telephone Number | 4. Name of Executive Director |
| 5. Period Cover |

|  |  |  |
| --- | --- | --- |
| This will certify that  |  | MD, |
| provided comprehensive primary care services to patients at the approved health facility site on a full time basis (minimum 40 hours/week) for the time period covered in this report with the exceptions (illness, vacation, CME program, etc.) specified below: |
| Inclusive Dates |  | Reasons |
|       |  |       |
|       |  |       |
|       |  |       |
|       |  |       |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 6. | **Type of Site Providers:** |  | Number | Total Hours/ Week\* | Biannual Visits |
|  | Family/General Practice |  |       |  |       |  |       |
|  | Internal Medicine |  |       |  |       |  |       |
|  | Pediatrics |  |       |  |       |  |       |
|  | Obstetrics/Gynecology |  |       |  |       |  |       |
|  | Dental (specify type) |  |  |  |  |  |  |
|  |       |  |       |  |       |  |       |
|  | Certified Nurse Midwife |  |       |  |       |  |       |
|  | Nurse Practitioner |  |       |  |       |  |       |
|  | Other: |  |  |  |  |  |  |
|  |       |  |       |  |       |  |       |
|  |       |  |       |  |       |  |       |

\*For example, if there are two providers working 20 hours and 40 hours/week respectively, the cumulative total would be 60 hours/week.

|  |  |
| --- | --- |
| 7. | Hours of Operation and Days Per Week: |
|  | Monday |       |  | Wednesday |       |  | Friday |       |
|  | Tuesday |       |  | Thursday |       |  | Saturday |       |
| 8. | Primary Service Area(s) (by city/township/borough/county): |
|  |       |

# INITIAL/BIANNUAL SERVICE REPORT, Continued

|  |
| --- |
| Name of Agency |
| **9.** | **Client Population:** |
|  | (In each category list the number of **unduplicated** clients and the number of biannual encounters for the reporting period): |
|  |  |  | Number of Clients |  | Number of Visits |
|  | Medicare \*\* |  |  |  |  |
|  | Medicaid \*\* |  |  |  |  |
|  | Sliding Fee Scale: |  |  |  |  |
|  |  Self Pay |  |  |  |  |
|  |  Uninsured |  |  |  |  |
|  | Commercial Insurance |  |  |  |  |
|  | Other (Specify): |  |  |  |  |
|  |  |  |  |  |  |
|  | Total: |  |  |  |  |

\*\*Include those enrolled in managed care organizations.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 10. | Children and Adolescents (0-21) |  |  |  |  |
| 11. | For this J-1 Visa Provider |  |  |  |  |
| 12. | Income Source (as a percent of total revenue) |
|  | Medicare |  |  | % |
|  | Medicaid |  |  | % |
|  | Sliding Fee Scale: |  |  |  |
|  |  Self Pay |  |  | % |
|  |  Uninsured |  |  | % |
|  | Commercial Insurance |  |  | % |
|  | Other (Specify): |  |  |  |
|  |       |  |  | % |
|  | Total |  |  | % |
| 13. | Do you accept new clients regardless of insurance type? |
|  | [ ]  Yes [ ]  No |
|  | a. If not, which of the above insurance groups are not accepted? |
|  |  |  |
| 14. | Cost Per Encounter: $ |  | (Divide total revenue by biannual encounters) |

|  |  |
| --- | --- |
| Name of Person Completing the Survey (Print) | Telephone Number**(** **)** |
| Title |
| Signature | Date |

*Your cooperation is greatly appreciated!*

*Please retain a copy of the survey and return the original to the address at the top of Page 1*