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*