New Jersey Department of Health

# Application for J-1 Visa Waiver / State Conrad 30 Program

Complete a separate application for each J-1 Visa Waiver.

Use the New Jersey J-1 Visa Waiver Guidelines to complete this application.

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|  Date Submitted: |  |  |
| 1. Name of Sponsoring Agency: |  |
| Street Address: |  |
| City: |  | County: |  |
| State: |  | Zip Code: |  |
| 2. Name of Sponsoring Agency Contact: |  |
| Title: |  | Telephone Number: | **(** **)** **-      (ex:      )** |
| 3. Practice Site Address (if different from above) |
| Address: |  |
| City: |  | County: |  | Zip Code: |  |
| 4. HPSA Type(s): |  |
| HPSA Service Area Number: |  |
| HPSA FIPS State/County Code: |  |
| Practice Site Service Area: |  |
| 5. Type of Practice: |
| [ ]  Public[ ]  Private Non-Profit[ ]  Private for Profit[ ]  Community/Migrant Health Center[ ]  Hospital-based Clinic[ ]  Private Practice[ ]  Group Practice[ ]  Health Department |
| [ ]  Other (Specify): |  |
| 6. Practice Site NJ Health Facility License Number: |  |
| Medicaid Provider Number: |  |
| Medicare Provider Number: |  |
| Practice Site Service Hours: |
|  | Weekday | Time | Total Hours |  |
|  | Start | End |  |
|  | Monday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
|  | Tuesday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
|  | Wednesday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
|  | Thursday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
|  | Friday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
|  | Saturday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |
| ***\* Schedule must indicate time services actually provided at site.*** |
| 7. Practice Site Primary Care Program (Check if On-Site or Referral) |
|  | Service Component | On-Site | ReferralOff-Site |  |
|  | Pediatric Care |  |  |  |
|  | Adult Care |  |  |  |
|  | Obstetrical Care  |  |  |  |
|  | Family Planning |  |  |  |
|  | Routine Physical |  |  |  |
|  | Routine Eye Care  |  |  |  |
|  | Routine GYN Care  |  |  |  |
|  | Routine Dental Exam  |  |  |  |
|  | Diagnostic X-Rays/Lab Tests |  |  |  |
|  | Mental Health/Substance Abuse |  |  |  |
|  | Nutrition Education/Counseling |  |  |  |
|  | Women, Infant, Children Food Program |  |  |  |
| 1. Describe Arrangements for Secondary, Tertiary and After Hours Care

**(NO ADDITIONAL SHEET ALLOWED)** |
|  |
| 9. Name of J-1 Physician: |  |
| Specialty: |  | Subspecialty: |  |
| 10. J-1 Physician Weekly Work Schedule: \* |
|  | Weekday | Time | Where(Hospital/Site) | Total Hours |  |
|  | Start | End |  |
|  | Monday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
|  | Tuesday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
|  | Wednesday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
|  | Thursday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
|  | Friday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
|  | Saturday |  [ ] AM/[ ] PM |  [ ] AM/[ ] PM |  |  |  |
| ***\* Schedule must indicate time J-1 Physician actually providing services at site.*** |
| 11. Complete Current Medical Staffing for the Practice Site: (**See Attachment A**) |
| Complete Health Care Resource Inventory: (**See Attachment B**) |
| 12. Number of Other J-1 Physicians at Practice Site: |  |
| Number of National Health Service Corps at Site: |  |
| 13. Practice Site Client Demographics: |
| Total Population of Service Area: |  |  |
| Total Number of Active Primary Care Clients Seen the Previous Calendar Year: |  |
| ***(This is NOT the number of encounters/visits)*** |
| Total Number of Active Primary Care Clients Encounters/Visits in the Previous Calendar Year: |  |
| 14. Percent of Practice Site Active Clients with Incomes at or Below 200 Percent of Federal Poverty Level: |
|  | Age Group | \* Medicaid | \* Medicare | + Sliding Fee Scale | Commercial |  |
|  | Birth – 11 Years | **%** | **%** | **%** | **%** |  |
|  | 12 – 18 Years | **%** | **%** | **%** | **%** |  |
|  | 19-62 Years | **%** | **%** | **%** | **%** |  |
|  | 63+ Years | **%** | **%** | **%** | **%** |  |
|  | Average % -  |  |  |  |  |  |
|  | HPSA: | **%** | **%** | **%** | **%** |  |
|  | Not HPSA: | **%** | **%** | **%** | **%** |  |
| \* This includes Medicaid/Medicare fee-for-service and managed care. |
| + Sliding Fee Scale would include clients with no insurance coverage (uninsured).SUBMIT SLIDING FEE SCALE AS [**ATTACHMENT C**](attachmentc.htm). |
| Practice Site Service Area 5-Year Average Rate for: |
| Infant Mortality: |  | Low Birthweight: |  |  |
| 15. Identify Practice Site Contiguous Service Area(s): |
|  |  |
|  |  |
| Average distance to the next nearest source of primary care that is available to the clients of this practice site using available public transportation: |
| Miles: |  | Minutes: |  |  |

| 1. What statistics demonstrate the J-1 Physician’s Specialty/Subspecialty is greatly needed in the practice service area?

***(ONE ADDITIONAL SHEET ALLOWED; PLEASE BE PRECISE)*** |
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|  |

| 1. Document that the Specialty/Subspecialty is not available to the service area indigent population:

 ***(ONE ADDITIONAL SHEET ALLOWED; PLEASE BE PRECISE)*** |
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| 1. Describe how the J-1 Physician will meet the service area indigent population needs:

 ***(NO ADDITIONAL SHEET ALLOWED)*** |
|  |
| 1. Describe the J-1 Physician’s unique qualifications, cultural match and experience to meet the service area indigent population primary care needs:

 ***(NO ADDITIONAL SHEET ALLOWED)*** |
|  |
| 1. Comprehensive summary of recruitment efforts within 6 months of requesting waiver for this J-1 Physician:

 ***(Attach copies of these recruitment efforts.)*** |
|  | Type of Advertisement | Date | Response/Dismissal Cause |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |
| 1. Describe the short or long-range plan for the retention of this J-1 Physician during and beyond three-year obligation:

***(No additional sheet allowed.)*** |
|  Short: |
|  |
|  Long: |
|  |
|  |