**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.*

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.***

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7. Practice Site Primary Care Program (Check if On-Site or Referral)

| Service Component | On-Site | Referral Off-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 | | |

8. 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**)

**APPLICATION FOR J-1 VISA WAIVER / STATE CONRAD 30 PROGRAM**
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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**.

    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: _____

16. 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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17. Document that the Specialty/Subspecialty is not available to the service area indigent population:
***(ONE ADDITIONAL SHEET ALLOWED; PLEASE BE PRECISE)***

18. Describe how the J-1 Physician will meet the service area indigent population needs:
***(NO ADDITIONAL SHEET ALLOWED)***

19. 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)***

20. 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 |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

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21. 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: