SITE APPLICATION FORMS

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

APPENDIX A

CONRAD STATE 30/J-1 VISA WAIVER
SITE APPLICATION FORMS

April 2007 Register of Regulations

I. SITE APPLICATION FORM

1. Sponsoring Site: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Non-Profit: _____ For Profit: _____

How many of the physicians currently practicing for the sponsoring site came to practice in Delaware through the J-1 Conrad Visa Waiver Program? _____

How many of the physicians currently practicing for the sponsoring site are in the process of completing their three year obligation?

_____

How many physicians completed the obligation and continued to practice at the sponsoring site?_____

Has the applicant sponsoring site employed any J-1 Visa physicians who are no longer practicing with them?
Yes ___ No ___

If you responded "yes", if you know, please tell us why they left and where are those physicians are practicing now?

_____
_____
_____
_____
_____

Please use additional space as needed.

2. Proposed Practice Site(s)

A. Name:
Address:

Telephone Number:
HPSA Number:
B. Name
Address:

Telephone Number:
HPSA Number:
C. Name:
Address:

Telephone Number:
HPSA Number:
D. Name:
Address:

Telephone Number:
HPSA Number:

3. Recruitment Contact:

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

4. Site A: _____

Name of Site

Data Regarding Active Clients

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Staffing Levels at Practice Site A

AREA OF PRACTICE	STAFFING	NUMBER OF J-1 PHYSICIANS REQUESTED	PROJECTED HIRE DATE			
	CURRENT		0-6 Months from site approval data	7-12 Months from site approval date	13-18 Months from site approval date	19-24 Months from site approval date
PRIMARY CARE PHYSICIANS						
Family Practice						
General Internal Medicine						
General Pediatrics						
Obstetrics/Gynecology						
Other (explain)						
SPECIALIST PHYSICIANS (Please Specify Specialty Area)						
NURSE PRACTITIONERS						
Family Nurse Practitioners						
Adult Nurse Practitioners						
Geriatric Nurse Practitioners						
Pediatric Nurse Practitioners						
Women's Health Nurse Practitioners						
Psychiatric Nurse Practitioners						
OTHER DISCIPLINES						
Physician Assistants						
Nurse Midwives						
Clinical Psychologists						
Clinical Social Workers						
Psychiatric Nurse Specialist						
Marriage and Family Therapists						

What are the practice hours of this facility?

DAY	TIME (Start and End)		TOTAL HOURS
Monday	AM:	PM:	
Tuesday	AM:	PM:	
Wednesday	AM:	PM:	
Thursday	AM:	PM:	
Friday	AM:	PM:	
Saturday	AM:	PM:	
Sunday	AM:	PM:	

Provide a separate work schedule for each J-1 physician requested and specify the specialty of each. If hours of operation vary by practitioner, please specify.
Please use additional space as needed.

5. Site B: _____

Name of Site

Data Regarding Active Clients

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Staffing Levels at Practice Site B

AREA OF PRACTICE	**STAFFING**	**NUMBER OF**	**PROJECTED HIRE DATE**			
	CURRENT	**J-1 PHYSICIANS REQUESTED**	**0-6 Months**	**7-12 Months**	**13-18 Months**	**19-24 Months**
PRIMARY CARE PHYSICIANS						
Family Practice						
General Internal Medicine						
General Pediatrics						
Obstetrics/Gynecology						
Other (explain)						
SPECIALIST PHYSICIANS (Please Specify Specialty Area)						
NURSE PRACTITIONERS						
Family Nurse Practitioners						
Adult Nurse Practitioners						
Geriatric Nurse Practitioners						
Pediatric Nurse Practitioners						
Women's Health Nurse Practitioners						
Psychiatric Nurse Practitioners						
OTHER DISCIPLINES						
Physician Assistants						
Nurse Midwives						
Clinical Psychologists						
Clinical Social Workers						

Psychiatric Nurse Specialist						
Marriage and Family Therapists						

What are the practice hours of this facility?

DAY	TIME (Start and End)		TOTAL HOURS
Monday	AM:	PM:	
Tuesday	AM:	PM:	
Wednesday	AM:	PM:	
Thursday	AM:	PM:	
Friday	AM:	PM:	
Saturday	AM:	PM:	
Sunday	AM:	PM:	

If hours of operation vary by practitioner, please specify.
Please use additional space as needed.

6. Site C: _____

Name of Site

Data Regarding Active Clients

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Staffing Levels at Practice Site C

AREA OF PRACTICE	STAFFING	NUMBER OF	PROJECTED HIRE DATE			
	CURRENT	J-1 PHYSICIANS REQUESTED	0-6 Months	7-12 Months	13-18 Months	19-24 Months
PRIMARY CARE PHYSICIANS						
Family Practice						
General Internal Medicine						
General Pediatrics						
Obstetrics/Gynecology						
Other (explain)						
SPECIALIST PHYSICIANS (Please Specify Specialty Area)						
NURSE PRACTITIONERS						
Family Nurse Practitioners						
Adult Nurse Practitioners						
Geriatric Nurse Practitioners						
Pediatric Nurse Practitioners						
Women's Health Nurse Practitioners						
Psychiatric Nurse Practitioners						
OTHER DISCIPLINES						
Physician Assistants						
Nurse Midwives						
Clinical Psychologists						
Clinical Social Workers						
Psychiatric Nurse Specialist						
Marriage and Family Therapists						

What are the practice hours of this facility?

DAY	TIME (Start and End)		TOTAL HOURS
Monday	AM:	PM:	
Tuesday	AM:	PM:	
Wednesday	AM:	PM:	
Thursday	AM:	PM:	
Friday	AM:	PM:	
Saturday	AM:	PM:	
Sunday	AM:	PM:	

If hours of operation vary by practitioner, please specify.
Please use additional space as needed.

7. Site D: _____

Name of Site

Data Regarding Active Clients

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Staffing Levels at Practice Site D

AREA OF PRACTICE	**STAFFING**	**NUMBER OF**	**PROJECTED HIRE DATE**			
	CURRENT	**J-1 PHYSICIANS REQUESTED**	**0-6 Months**	**7-12 Months**	**13-18 Months**	**19-24 Months**
PRIMARY CARE PHYSICIANS						
Family Practice						
General Internal Medicine						
General Pediatrics						
Obstetrics/Gynecology						
Other (explain)						
SPECIALIST PHYSICIANS (Please Specify Specialty Area)						
NURSE PRACTITIONERS						
Family Nurse Practitioners						
Adult Nurse Practitioners						
Geriatric Nurse Practitioners						
Pediatric Nurse Practitioners						
Women's Health Nurse Practitioners						
Psychiatric Nurse Practitioners						
OTHER DISCIPLINES						
Physician Assistants						
Nurse Midwives						

Clinical Psychologists						
Clinical Social Workers						
Psychiatric Nurse Specialist						
Marriage and Family Therapists						

What are the practice hours of this facility?

DAY	TIME (Start and End)		TOTAL HOURS
Monday	AM:	PM:	
Tuesday	AM:	PM:	
Wednesday	AM:	PM:	
Thursday	AM:	PM:	
Friday	AM:	PM:	
Saturday	AM:	PM:	
Sunday	AM:	PM:	

If hours of operation vary by practitioner, please specify.
Please use additional space as needed.

II. NEEDS ASSESSMENT

Please use additional paper to complete this section. The Needs Assessment should include the following:

- Description of the service area in which the sponsoring site's patients are located in the surrounding/local area.
- A geographic services area health resource inventory, including all medical services and practices in the surrounding area.
- Description of the nearest available sites providing services similar to the proposed J-1 practice site, including miles to the nearest site and travel time.

Please be thorough.

1. Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA) Documentation.

For each practice site provide the following information:

Practice Site A:

HPSA Y/N Location: _____
MUA Y/N: Location _____
Sponsoring Site's Primary Service Area
(City, County, Zip Code & Census Tract) _____
City Zip Code Census Tract

Practice Site B:

HPSA Y/N Location: _____
MUA Y/N: Location _____
Sponsoring Site's Primary Service Area
(City, County, Zip Code & Census Tract) _____
City Zip Code Census Tract

Practice Site C:

HPSA Y/N Location: _____

MUA Y/N: Location _____

Sponsoring Site's Primary Service Area
(City, County, Zip Code & Census Tract) _____

City Zip Code Census Tract

Practice Site D:

HPSA Y/N Location: _____

MUA Y/N: Location _____

Sponsoring Site's Primary Service Area
(City, County, Zip Code & Census Tract) _____

City Zip Code Census Tract

Information regarding the Health Professional Shortage Areas and Medically Underserved Areas can be found out at the following web sites:

http://bphc.hrsa.gov/databases/newmua/

http://bhpr.hrsa.gov/shortage/

http://hpsafind.hrsa.gov/

2. Documentation of a shortage in the defined service area for the particular physician specialty being requested under the J-1 Visa Waiver Program.

a) Provide statistics demonstrating the specialty/sub-specialty is greatly needed in the proposed practice site's service area(s).

b) Document that the specialty/sub-specialty is not currently available to sufficiently meet the need in the service area(s) for the underserved population.

c) Describe how a J-1 physician will be used to meet the underserved population needs in the service area(s); discuss any unique qualifications, such as language/cultural match or experience with a population similar to those in the service area, are sought to meet a particular need.

III. RETENTION

Thoroughly describe the short and long-range plan for the retention of a J-1 physician beyond the required three-year obligation. Please use additional paper.

IV. PROOF OF FAILED RECRUITMENT ATTEMPTS

DATE	METHOD OF RECRUITMENT	RESPONSE	REASON FOR DISCONTINUING METHOD

The sponsoring site must provide proof that attempts have been made to hire a physician with United States citizenship throughout the past six months to no avail. This section must include a written description of the failed attempts to recruit as well as back up documentation including, but not limited to, copies of medical journal and newspaper advertisements, letters to medical residency programs and/or medical schools, etc. Please include dates indicating the frequency of the advertisements and/or other attempts. Please state any attempts to gain recruitment support from the hospital within the practice site's geographic service area. Submit documentation of all recruitment attempts.

V. LETTERS OF SUPPORT

The sponsoring site must submit at least three letters of support from community members without financial interest in the practice site who reside in the site(s) service area. Each letter must indicate the benefits of, or need for, the placement of a J-1 physician with the sponsoring site. ***At least one letter must be from an elected public official, at least one letter must be from a medical professional and at least one letter must be from an individual representing the patient population.***

Attach original, signed letters from these three separate community members and/or leaders in the practicing site's service area.

~~Attach original, signed letters from two separate community members and/or leaders in the practicing site's service area. Attach one original, signed letter from an approved local Public Health official (see Appendix B for an approved contact list).~~

VI. SPONSORING SITE WAIVER AGREEMENT

Delaware Health and Social Services (DHSS) is committed to ensuring that all residents have access to quality, affordable health care. Accordingly, DHSS is prepared to consider recommending a waiver of the foreign residence requirement on behalf of physicians holding J-1 Visas under certain conditions. Therefore, the additional requirements are deemed necessary to support our Conrad State 30/J-1 Visa Waiver Program.

The director or applicant official for the facility or practice **must initial all** of the following requirements:

	Sponsoring site agrees to comply with all of the Program requirements set forth in this Agreement and guidelines.
	The sponsoring site is located in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), as designated by the Secretary of Delaware Health and Human Services.
	The J-1 physician will provide medical care for at least forty (40) hours a week at the HPSA or MUA site named in the application for a minimum of three (3) years. Travel or on-call time is not included in the required forty (40) hours.
	The sponsoring site agrees to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services, or (b) payment for those health services will be made under Medicaid and Medicare. The sponsoring site will charge persons receiving services at the usual and customary rate prevailing in the HPSA/MUA in which services are provided, except charges will be on a sliding scale for persons at or below 200 percent of poverty or at no charge for persons unable to pay for these services.
	The sponsoring site agrees to enroll in the VIP II Program within 30 days of submitting this application or provide documentation that the site is already a CHAP-VIPII network provider.

	The sponsoring site has made a reasonable, good faith effort to recruit a physician with United States citizenship for the job opportunity in the same salary range without success throughout during the last 6 months immediately preceding this request for a waiver. Recruitment efforts were through a number of appropriate sources most likely to bring responses from able, willing, qualified and available physicians with United States citizenship.
	I understand and acknowledge that the review of this site application is discretionary and that in the event a decision is made not to approve the site application, I hold harmless the State of Delaware, DHSS and any and all State employees and/or any and all individuals or organizations involved in the review process from any action or lack of action made in connection with this request
	I agree to notify the J-1 Program Manager at the Division of Public Health in writing the start date of employment of the J-1 physician within 15 days of execution of the employment contract and provide a copy of the employment contract.
	I agree to adhere to all provisions of these regulations, including the contract provisions (see VII. D. Contract)

VII. SIGNATURE

Signature of Applicant Official: _____

Title: _____ Date: _____

Printed or Typed Name: _____

LETTER OF SUPPORT CONTACT LIST

~~DELAWARE HEALTH AND SOCIAL SERVICES~~
~~DIVISION OF PUBLIC HEALTH~~

~~APPENDIX B~~

~~CONRAD STATE 30/J-1 VISA WAIVER~~
~~J-1 PHYSICIAN APPLICATION LETTER OF SUPPORT CONTACT LIST~~

J-1 PHYSICIAN APPLICATION
LETTER OF SUPPORT CONTACT LIST

The following are approved public health officials to contact to obtain a letter of support to include with the J-1 Visa Waiver Site Application. If the practice site is located in New Castle County, please contact Anita Muir. If the practice site is located in Kent or Sussex Counties, please contact Barbara DeBastiani.

Northern Health Services
Anita Muir, Administrator
2055 Limestone Road, Suite 300
Wilmington, DE 19808

Phone: (302) 995-8632
Fax: (302) 995-8616

Southern Health Services
Barbara DeBastiani, Administrator
Sussex County Health Unit
544 South Bedford Street
Georgetown, DE 19947

Phone: (302) 856-5355
Fax: (302) 856-5065

Phone number: _____ E-mail: _____

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

J-1 PHYSICAN APPLICATION FORMS

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

APPENDIX B

CONRAD STATE 30/J-1 VISA WAIVER
J-1 PHYSICIAN APPLICATION FORMS

J-1 VISA WAIVER REQUEST
DOS PHYSICIAN DATA SHEET

1. FULL NAME: _____

2. DATE OF BIRTH: _____ PLACE OF BIRTH: _____

3. COUNTRY OF NATIONALITY OR LAST LEGAL PERMANENT RESIDENCE: _____

4. DATE AND PLACE OF ISSUANCE OF ORIGINAL EXCHANGE-VISITOR (J-1) VISA:

_____

5. PRESENT HOME ADDRESS: IMMIGRATION DISTRICT: _____

_____

_____

_____

6. HOME TELEPHONE: _____
BUSINESS TELEPHONE: _____
EMAIL ADDRESS _____

7. LIST OF EXCHANGE-VISITOR PROGRAMS IN WHICH YOU PARTICIPATED. IF KNOWN, GIVE THE PROGRAM NUMBER AND THE FIELD OF SPECIALIZATION:

_____ _____

_____ _____

_____ _____

8. ALIEN REGISTRATION NUMBER, IF KNOWN: _____

9. IF YOUR EXCHANGE-VISITOR PROGRAM INCLUDES US GOVERNMENT FUNDS, FUNDS FROM YOUR OWN GOVERNMENT, OR FROM AN INTERNATIONAL ORGANIZATION. PLEASE GIVE FULL PARTICULARS CONCERNING THE FUNDING ON A SEPARATE SHEET.

10. IS YOUR SPOUSE IN J-1 STATUS? YES NO
IF SO, IS HE/SHE ALSO APPLYING FOR A WAIVER? (PLEASE GIVE A FULL EXPLANATION ON A SEPARATE SHEET)

11. GIVE THE REASONS FOR NOT WISHING TO FULFILL THE TWO YEAR HOME COUNTRY RESIDENCE REQUIREMENT TO WHICH YOU AGREED AT THE TIME YOU ACCEPTED EXCHANGE VISITOR STATUS. PLEASE GIVE A FULL EXPLANATION ON A SEPARATE SHEET.

12. PLEASE INCLUDE COPIES OF ALL IAP-66 FORMS ISSUED DURING YOUR STAY IN THIS COUNTRY.

_____ _____

SIGNATURE OF J-1 PHYSICIAN APPLICANT **DATE**

DECLARATION OF PENDING INTERESTED GOVERNMENT AGENCY

I, _____, hereby declare and certify, under penalty of the provisions of 18 U.S.C. 1101, that I do not now have pending nor am I submitting during the pendency of this request, another request to any United States Government agency or any State Department of Public Health, or equivalent, other than the Delaware Health and Social Services to act on my behalf in any matter relating to a waiver of my two-year-home-country physical presence requirement.

_____ _____
Physician Signature Date

_____
Physician Name (Printed or Typed)

MEDICAL LICENSE AFFIDAVIT

I, _____, hereby affirm that, to the best of my knowledge, my medical license has never been suspended or revoked and that I am not subject to any criminal investigation or proceedings by any medical authority.

_____ _____
Physician Signature Date

_____
Physician Name (Printed or Typed)

DELAWARE HEALTH AND SOCIAL SERVICES

J-1 PHYSICIAN WAIVER AFFIDAVIT AND AGREEMENT

I, _____, being duly sworn, hereby request the Delaware Health and Social Services (DHSS) to review my application for the purpose of recommending waiver of the foreign residency requirement set forth in my J-1 Visa, pursuant to the terms and conditions as follows:

1. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to grant my request, I hold harmless the State of Delaware, DHSS, any and all State employees and/or any and all individuals or organizations involved in the review process from any action or lack of action made in connection with this request.

2. I further understand and acknowledge that the entire basis for the consideration of my request is DHSS's mission to improve the availability of medical care in areas designated as Health Professional Shortage Areas (HPSA) and Medically Underserved Areas (MUA) by the Secretary of the Department of Health and Human Services.

3. In understand and agree that in consideration for a waiver, which may or may not be granted, I shall render medical care services to patients, including the underserved, for a minimum of forty (40) hours per week at the following designated HPSA or MUA sites in Delaware:

Such service shall commence not later than three months (90 days) after I receive notification of approval by the United State Immigration and Naturalization Services (INS) and shall commence for a minimum of three (3) years as required by State policy guidelines.

4. I have incorporated all terms of this Physician J-1 Visa Waiver Affidavit and Agreement into the executed employment contract attached to this request.

5. I further agree that my executed employment contract with the sponsoring site does not contain any provision which modifies or amends any terms of the Program guidelines for Delaware and this Physician J-1 Visa Waiver Affidavit and Agreement.

6. I agree to provide health care services to Medicare, Medicaid and medically underserved patients, without discrimination based upon ability to pay for such services (i.e. self-pay, sliding fee scale, charity care).

7. I agree to provide health services to individuals without discriminating against them because (a) they are unable to pay for those services or (b) payment for those health services will be made under Medicaid and Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA in which services are provided, except charges will be on a sliding scale for persons at or below 200 percent of poverty or at no charge for persons unable to pay for these services.

8. I agree to enroll in the VIP II Program within 60 days of my start date under the Conrad State 30 Program.

9. I understand I must submit a "No Objection" letter if my home country's government funded my graduate medical education.

10. I have not been "out of status" (as defined by the Immigration and Naturalization Service of the United States Department of Justice) for more than six (6) months since receiving a visa under 8 U.S.C. 1182 (j) of the Immigration and Nationality Act, as amended.

11. I understand the Declaration of Pending Interested Government and Medical Licensure Affidavit and signed both statements.

12. I expressly understand I am to provide written notification of the specific location and nature of my practice to DHSS at the time I receive notification from USCIS and I commence rendering services in the HPSA or MUA. I further understand and agree that my relocation from a site approved in the application request to a new site must be approved by DHSS in writing prior to the move.

13. I understand that if I fail to fulfill the terms of my employment contract with the sponsoring site named in this application, I become subject to the two-year foreign residence requirement, and am ineligible to apply for an immigrant visa, permanent residence, or any other change of immigrant status until the two-year foreign residence requirement is met.

14. I expressly understand and acknowledge the scope of the Delaware Conrad State 30/J-1 Visa Waiver Program guidelines and all the information contained in my application request submitted by _____ on my behalf.

15. I understand that I am responsible for ensuring that annual reporting requirements are met by myself and my employer in a timely manner in accordance with the Delaware Conrad State 30/J-1 Visa Waiver Program procedures. I agree to fully cooperate with and participate in an exit interview within 90 days prior to completing my three-year practice obligation.

I declare under penalties of perjury that all the information provided to DHSS for the purposes of determining whether it will act as an "Interested Government Agency" is true and correct.

_____ _____

J-1 Physician Signature Date

_____

J-1 Physician Name (Printed or Typed)

Subscribed to and sworn before me this _____ day of _____, 20____.

_____ _____

Notary Public Signature Date

DELAWARE HEALTH AND SOCIAL SERVICES
J-1 VISA WAIVER APPLICATION CHECKLIST

The requesting J-1 physician applicant must initial that each required enclosure has been included in the application package for review by the Delaware Health and Social Services.

_____ DOS Physician Data Sheet (DOS & DPH)

_____ All IAP-66 Forms and INS Forms 1-94 (DOS & DPH)

_____ No Objection Letter (If Required)

_____ Physician Curriculum Vitae (DOS & DPH)

_____ Three (3) Letters of Recommendation

_____ Copy of All Residency/Fellowship Certificates

_____ Copy of Delaware Medical License (Or Proof of Eligibility)

_____ Copy of Board Eligibility/Certification

_____ Executed Employment Contract

_____ Check to the State of Delaware from the sponsoring site for $250 non-refundable fee per applicant

_____ A personal statement for not wishing to fulfill two-year residency requirement (DOS & DPH)

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

SITE APPLICATION EVALUATION WORKSHEET

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

APPENDIX C

CONRAD STATE 30/J-1 VISA WAIVER
SITE APPLICATION EVALUATION WORKSHEET

J1 VISA WAIVER APPLICATION
Site Application Evaluation Worksheet

Review Element	***Possible Weight***	***Assigned Points***	***Comments***
1. Site Application Documentation:	**25**		
• Site data regarding active clients	**15**		
• Staffing levels	**5**		
• Practice site hours of operation	**5**		
2. Needs Assessment Total: (must score at least 25 to qualify)	**35**		
• Description of geographic service area	**10**		
• Geographic service area health resource inventory	**5**		
• Documentation of primary care or specialty shortage	**20**		
3. Retention:	**15**		
• Documents short-term plan to retain J-1 physician	**5**		
• Documents long-term plan to retain J-1 physician at the end of the three-year obligation.	**10**		
4. Proof of Failed Recruitment Attempts:	**15**		
• Documented proof of failed attempts to recruit	**15**		
5. Letters of Support:	**10**		
• Three letters of support from community members and/or leaders without financial interest in the practice site who reside in the practice site's service area. Each letter must indicate the benefits of, or need for, the placement of a J-1 physician. At least one letter must be from an elected official. At least one letter must be from a medical professional. At least one letter must be from an individual representing the patient population.	**10**		
Total (the total must equal at least 70 for approval)	**100**		

ANNUAL PRACTICE REPORT

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

APPENDIX D

CONRAD STATE 30/J-1 VISA WAIVER
ANNUAL PRACTICE REPORT

DELAWARE HEALTH
AND SOCIAL SERVICES
Division of Public Health

Conrad State 30/J-1 Visa Waiver Program
Annual Practice Report
To Be Completed By Approved Practice Site

1. Name of J-1 Physician: _____

Start Date: _____

2. Sponsoring Site: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Non-Profit: _____ For Profit: _____

3. J-1 Practice Site(s): _____

A. Name:
Address:

B. Name
Address:

C. Name:
Address:

D. Name:
Address:

4. Contact Person: _____

Street Address: _____

City: _____ State: _____ Zip: _____ County: _____

Telephone Number: _____ Fax Number: _____

E-Mail Address: _____

Type of Service(s) Provided:

Please provide the medical specialties practiced by the J-1 physician, the total hours he/she worked in each specialty and the number of annual visits performed by this physician.

Practice Type	Total Hours/Week	Annual Visits
A.		
B		
C.		
D.		

J-1 Physician's Hours of Operation:

Indicate the weekly work schedule of the J-1 physician. Include the number of hours (with start and end times) and the primary location (hospital/practice site). The schedule must indicate the time the J-1 physician is actually providing services; do not include travel or on-call time. If the J-1 physician is practicing at more than one location, please complete a schedule for each location.

Practice Site A:

DAY	Location	TIME (Start and End)		TOTAL HOURS
Monday		AM:	PM:	
Tuesday		AM:	PM:	
Wednesday		AM:	PM:	
Thursday		AM:	PM:	
Friday		AM:	PM:	
Saturday		AM:	PM:	
Sunday		AM:	PM:	

Practice Site B:

DAY	Location	TIME (Start and End)		TOTAL HOURS
Monday		AM:	PM:	
Tuesday		AM:	PM:	
Wednesday		AM:	PM:	
Thursday		AM:	PM:	
Friday		AM:	PM:	
Saturday		AM:	PM:	
Sunday		AM:	PM:	

Practice Site C:

DAY	Location	TIME (Start and End)		TOTAL HOURS
Monday		AM:	PM:	
Tuesday		AM:	PM:	
Wednesday		AM:	PM:	
Thursday		AM:	PM:	
Friday		AM:	PM:	
Saturday		AM:	PM:	
Sunday		AM:	PM:	

Practice Site D:

DAY	Location	TIME (Start and End)		TOTAL HOURS
Monday		AM:	PM:	
Tuesday		AM:	PM:	
Wednesday		AM:	PM:	
Thursday		AM:	PM:	
Friday		AM:	PM:	
Saturday		AM:	PM:	
Sunday		AM:	PM:	

If hours to be worked do not conform to the table provide above, please explain in the space below the differences or exceptions.

Site Data Regarding Active Clients:

Provide the total number of active patients at the practice site(s) in the previous calendar year with totals, as applicable, for primary care, specialty care and mental health services.

Site A: _____

Name of Site

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Please provide a breakdown of each of the following payor types by age of patient.

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Site B: _____

Name of Site

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Please provide a breakdown of each of the following payor types by age of patient.

Patient Population by Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Site C: _____

Name of Site

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Please provide a breakdown of each of the following payor types by age of patient.

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

Site D: _____

Name of Site

Total Number of Patients Receiving the Following Medical Services Annually:

Primary Health Care _____ Specialty Care _____ Mental Health Care _____ TOTAL _____

Total Users in Previous Calendar Year Below 200% of Federal Poverty Level _____

Please provide a breakdown of each of the following payor types by age of patient.

Patient Population By Payor Mix (totals will equal 100%)

AGE GROUP	% MEDICAID	% MEDICARE	% SLIDING FEE SCALE	% COMMERCIAL	% PRIVATE PAY	ROW TOTALS
Birth – 11 Years						
12- 18 Years						
19-62 Years						
63+ Years						
COLUMN TOTALS						

This will certify that _____ (name of J-1 physician) provided medical services to patients at the approved health facility site(s) on a full-time basis (minimum forty hours per week) for the time period of _____ through _____.

Signature of Applicant Official: _____

Title: _____ Date: _____