Bureau for Public Health
Office of Community Health Systems & Health Promotion
Division of Rural Health & Recruitment
State Office of Rural Health
350 Capitol Street, Room 515
Charleston, WV, 25301-3717
(304) 352-6035

J-1 Visa Waiver Program: Reporting & Monitoring

Physicians admitted to West Virginia's J-1 Visa Waiver Program are held accountable to the protocols outlined in the West Virginia Affidavit and Agreement, and this document, as are healthcare facilities which employ J-1 physicians. A physician who fails to uphold these policies risks being reported as noncompliant to the United States Citizenship and Immigration Services (USCIS), which may ultimately result in deportation. A facility that fails to comply with these policies risks eligibility for future participation in the Program. For further information or inquiries, please contact:

Wendy Castaneda
J-1 Visa Waiver Coordinator for the WV State Office of Rural Health
Email: wendy.p.castaneda@wv.gov Phone: (304) 352-6005

Requirements:

1. The West Virginia State Office of Rural Health (SORH), located within the West Virginia Department of Health (WVDH) will conduct periodic monitoring of all J-1 visa waiver physicians through site visits, telephone calls, or requests for written reports.
2. The physician and employer must submit to the SORH semiannual reports about the population served. The first report must be submitted within 30 days of employment. Subsequent reports are submitted in January and July of each year for the full three-year commitment. Reporting forms will be supplied to the physician and the sponsoring employer by the SORH.
3. Within 30 days of the physician's start date, physician and employer are responsible for submitting a Placement Verification Form, along with a copy of the written notification of approval from USCIS. Placement Verification Forms will be supplied by the SORH.
4. SORH representatives, while maintaining strict confidentiality and complying with all HIPAA regulations, are permitted to access records maintained by a physician's practice that are relevant to adhering to these guidelines. This access will be granted upon reasonable notice and during normal business hours, and may include performing audits for compliance.
5. If the employment contract is terminated prior to its scheduled end date, the J-1 Physician and Employer must provide written notification and explanation to the SORH. Under no circumstance should a relocation of a J-1 Waiver recipient occur without prior written authorization by the SORH.
    a. The employer of a J-1 Waiver Physician that transfers to another medical facility within West Virginia must submit a final report upon termination of the contract.
    b. The new employer of a J-1 Physician who has transferred from within West Virginia or another state must file the first work verification report within 30 days of the transfer.

Physician Name: _____

Medicare Provider Number: _____ **Medicaid Provider Number:** _____

Reporting Period:

Period 1: January-June Circle if Applicable: **Period 1** Or **Period 2** **Reporting Yr:** _____
Period 2: July-December

**List dates if periods are N/A: _____ To _____

Specialty: _____ **Sub-specialty**:_____ **Primary Care:** Yes Or No

Name of Sponsor:_____

Clinical Practice Site Information: Please complete all fields. If a field is not applicable, write "N/A" (not applicable) in the designated space. *Leaving fields blank may result in delays or rejection of this document.* If there is more than one location, please use Addendum.

Site Name: _____

Site Address: _____ County:_____

Please list a **typical work schedule** during this reporting period:

Monday From _____ To _____
Tuesday From _____ To _____
Wednesday From _____ To _____
Thursday From _____ To _____
Friday From _____ To _____
Saturday From _____ To _____
Sunday From _____ To _____

Total Clinical hours worked each week: _____

Please Answer the Following:

Is the practice site located in a health professional shortage area **(HPSA)?** ☐ Yes ☐ No ☐ N/A

Is the practice site located in a medically underserved area **(MUA)?** ☐ Yes ☐ No ☐ N/A

Is the practice site located outside of a shortage designation area but treats patients that reside in shortage areas **(FLEX10 Slot)?** ☐ Yes ☐ No ☐ N/A

Site **HPSA** ID: _____ Site **MUA** ID: _____

Does the practice site participate in the **WV Medicaid Program?** ☐ Yes ☐ No

Does the practice site accept new **WV Medicaid users?** ☐ Yes ☐ No

Does the practice site accept **Medicare?** ☐ Yes ☐ No

For this reporting period:

a. Number of **office** visits (do not include telephone consultations or hospital visits): _____

b. Number of visits from **4a who reside in a HPSA/MUA:** _____

c. Number of **hospital** visits: _____

d. Number of patient visits for whom a **Medicare** claim was submitted: _____

e. Number of patient visits for whom a **Medicaid** claim was submitted: _____

f. Number of patients wherein services were **rendered at a rate less than usual and customary fee, i.e., sliding fee:** _____

g. Number of patient visits for which **no charge** was made (based on inability to pay): _____

PHYSICIAN CERTIFICATION

I hereby certify **under penalty of licensure action and possible revocation of my J-1 waiver** that I, the undersigned physician, personally delivered the type of health care services for which my J-1 waiver was approved at the above address(es) at least 40 clinical hours per week. I further certify that my practice is using a sliding fee scale or a financial assistance policy for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level. **All the information reported on this form is true to the best of my knowledge and belief.**

Physician's Name: _____ Date: _____
Printed

Physician's Signature: _____

SPONSOR / EMPLOYMENT VERIFICATION

I hereby certify **under penalty of licensure action and other liability for fraudulent claims** that the information provided on this report is true and correct to the best of my knowledge and belief. I further certify that this organization uses a sliding fee scale or a financial assistance policy submitted with the above J-1 Physician's waiver application to discount payment fees for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level.

Representative's Name: _____ Date: _____
Printed

Representative's Signature: _____

Use this addendum to list any additional clinical practice sites beyond the primary one. Attach as many needed to list all practicing sites. Please complete all fields. If a field is not applicable, write "N/A" (not applicable) in the designated space. ***Leaving fields blank may result in the rejection of this required reporting form.***

Site Name: _____

Site Address: _____ County:_____
Street *City* *State* *Zip Code*

Please list a **typical work schedule** during this reporting period:

Monday From _____ To _____
Tuesday From _____ To _____
Wednesday From _____ To _____
Thursday From _____ To _____
Friday From _____ To _____
Saturday From _____ To _____
Sunday From _____ To _____

Total Clinical hours worked each week: _____

Please Answer the Following:

Is the practice site located in a health professional shortage area **(HPSA)?** ☐ Yes ☐ No ☐ N/A
Is the practice site located in a medically underserved area **(MUA)?** ☐ Yes ☐ No ☐ N/A
Is the practice site located outside of a shortage designation area but treats patients that reside in shortage areas **(FLEX10 Slot)?** ☐ Yes ☐ No ☐ N/A

Site **HPSA** ID: _____ Site **MUA** ID: _____

Does the practice site participate in the **WV Medicaid Program?** ☐ Yes ☐ No
Does the practice site accept new **WV Medicaid users?** ☐ Yes ☐ No
Does the practice site accept **Medicare?** ☐ Yes ☐ No

For this reporting period:

a. Number of **office** visits (do not include telephone consultations or hospital visits): _____
b. Number of visits from **4a who reside in a HPSA/MUA:** _____
c. Number of **hospital** visits: _____
d. Number of patient visits for whom a **Medicare** claim was submitted: _____
e. Number of patient visits for whom a **Medicaid** claim was submitted: _____
f. Number of patients wherein services were **rendered at a rate less than usual and customary fee, i.e., sliding fee:** _____
g. Number of patient visits for which **no charge** was made (based on inability to pay): _____