WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH
OFFICE OF COMMUNITY HEALTH SYSTEMS AND HEALTH PROMOTION
DIVISION OF RURAL HEALTH AND RECRUITMENT
STATE OFFICE OF RURAL HEALTH

REPORTING AND MONITORING GUIDELINE

INTRODUCTION

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 after being admitted to the Program, 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.

REPORTING AND MONITORING REQUIREMENTS

The WV State Office of Rural Health (SORH) located within the West Virginia Department of Health and Human Resources (DHHR) will conduct periodic monitoring of all J-1 Visa Waiver physicians either through site visits, telephone calls, or requests for written reports.

The physician and employer must submit to the SORH semi-annual 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 Department.

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 SORH.

The physician and/or employer shall, upon reasonable notice and during normal business hours, grant SORH representatives, who shall maintain full confidentiality and comply with HIPAA regulations, reasonable access to all records maintained by the physician's practice, which are pertinent to ascertaining compliance with these guidelines. WV State Office of Rural Health (SORH) representatives may perform audits for compliance of these guidelines.

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 SHOR. Prior to processing National Interest Waiver requests, the physician's Verification of Employment Form and the semi-annual Reporting Forms must have been submitted to the SORH.

Under no circumstance should a relocation of a J-1 Visa Waiver recipient occur without prior written authorization by the SORH.

- The employer of a J-1 Physician that transfers to another medical facility within West Virginia must submit a final report upon termination of the contract.
- 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.

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Office of Community Health Systems and Health Promotion
Division of Rural Health and Recruitment
State Office of Rural Health
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J-1 Visa Waiver Program Reporting Form

Reporting Period: _____ to _____

Name of Physician: _____ Specialty: _____

Name of Sponsor: _____

Clinical Practice Name: _____

_____

Street City County State Zip

Clinical Practice Name: _____

_____

Street City County State Zip

Clinical Practice Name: _____

_____

Street City County State Zip

My typical work schedule during this reporting period has been as follows:

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: _____

In addition to the hours at the above site address, approximately _____ hours per week were required to treat patients at _____Hospital.

During this reporting period, I was absent from the practice for _____ days due to illness, vacation, or for continuing professional education.

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): _____

My Medicare Provider Number is: _____

My Medicaid Provider Number is: _____

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 at least 40 clinical hours per week. I further certify that my practice is using the sliding fee scale or 'no-pay' policy submitted with my J-1 waiver application 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.

Print or Type Physician Name: _____

Physician Signature: _____

Date: _____

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 the sliding fee scale or 'no-pay' 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.

I certify that the Provider's Official start date of employment is or was: _____

Sponsor Name: _____

Employer's Signature: _____

Title: _____

Date: _____