## Department of Health Office of Community Health Systems and Health Promotion Division of Rural Health and Recruitment 350 Capitol Street, Room 515 Charleston, West Virginia 25301-3716

## APPLICATION FOR SITE APPROVAL FOR J-1 VISA WAIVER PLACEMENT

| 1. | Sponsor:  |  |                       | Date:            |                                 |     |  |
|----|---|--|-----------------------|------------------|---------------------------------|-----|--|
|    | Address:  | Street   | City                  |                  | Zip Code                        |     |  |
|    |   | on:  |                       |                  |                                 |     |  |
|    |   |  |                       | Email:           |                                 |     |  |
| 2. | Practice address (if different) from Sponsor's address above - Please list all, if more than one location |  |                       |                  |                                 |     |  |
|    | Facility Name   | Street   |                       | City             | Zip Code                        |     |  |
|    | Facility Name   | Street   |                       | City             | Zip Code                        |     |  |
|    | Facility Name   | Street   |                       | City             | Zip Code                        |     |  |
| 3. | ls the practic<br>□ No  | e site located in a health p   | rofessional shortage  | area on the 2022 | list (HPSA)?                    | (es |  |
| 4. |   | e site located in a medical  | ly underserved area ( | MUA) on the 2022 | 2 list? □ Yes □ No              |     |  |
| 5. |   | Is the Practice site located in a medically underserved area (MUA) on the 2022 list?  Yes No Please list ID number of HPSA Please list ID number of MUA                                  |                       |                  |                                 |     |  |
| 6. | Is the Practic  | he Practice site located outside of a shortage designation area but see patients that reside in ortage areas (FLEX10 Slot)? □ Yes □ No   |                       |                  |                                 |     |  |
| 7. | Type of Pract   | tice   |                       |                  |                                 |     |  |
|    | Certifi     Critica     Free C     Federa     Comm  | ally Qualified Health Center<br>ed Rural Health Clinic<br>al Access Hospital<br>Clinic<br>ally Qualified Health Center L<br>nunity Mental Health agency<br>s (can you please add line wh | ook-A like            | write it in)     |                                 |     |  |
| 8. | Type of Organization  |  |                       |                  |                                 |     |  |
|    | <ul> <li>For- P</li> <li>Non- F</li> <li>Public</li> </ul>  | Profit   |                       |                  |                                 |     |  |
| 9. | Physician Specialty (Select all apply)  |  |                       |                  |                                 |     |  |
|    | A.  |  | eriatrics             |                  | Children/Adolescent<br>r it in) |     |  |
|    | B. Speci  | alty:  | Sub-spec              | ialty:           |                                 |     |  |

| Day       | Hours | Location |
|-----------|-------|----------|
| Monday    |       |          |
| Tuesday   |       |          |
| Wednesday |       |          |
| Thursday  |       |          |
| Friday    |       |          |
| Saturday  |       |          |
| Sunday    |       |          |

11. Has the health care facility, where the J-1 physician will be working been in operation as a health care facility for a minimum of 2 years?

🗆 Yes 🛛 🗆 No

12. Does the facility have an open policy to see all patients regardless of their ability to pay for services?

□ Yes □ No (If yes, attach a copy of your sliding fee schedule)

13. Dose the facility have a notice conspicuously posted of the availability of the sliding fee schedule?

□ Yes □ No (Submit a copy of the public notice)

- 14. Dose the facility participate in WV Medicaid Program? 
  Ves No
- 16. Dose the facility accept Medicare? 

  □ Yes 
  □ No
- 17. Will the J-1 physician have hospital privileges? 
  Ves 
  No

If yes, where: \_\_\_\_\_

18. Patients by insurance coverage for past twelve (12) Months by the practice site where the J-1 Physician will practice

|                            | Number | Percentage |
|----------------------------|--------|------------|
| Medicaid                   |        |            |
| Medicare                   |        |            |
| Commercial Insurance       |        |            |
| Self- Pay/ Private Pay     |        |            |
| Sliding Fee Scale Visits   |        |            |
| Individuals not<br>charged |        |            |
| Total                      |        |            |

The narrative for this application is to be prepared on a separate sheet of paper. Please remember, the West Virginia J-1 Visa Waiver Program is very competitive and only well-documented applications that meet minimum requirements will be approved.

19. Provide proof that a good faith effort has been made to recruit a U.S. citizen physician for this position at the same salary range without success during the past six months.

Attach copies of ads in newspapers and professional journals; include contacts with residency programs and professional recruiting firms. Submit an overall summary of your recruitment efforts including the number of U.S. doctors who responded to your advertisements, how many were interviewed and the interview outcome.

- 20. Provide letters from local primary care physicians supporting the specialist or sub-specialist from other facilities.
- 21. Document the shortage of this specialty or sub-specialty in the service area. Provide data on major health problems in the community related to the need for this specialty or sub-specialty. (e.g. endocrinologists in an area with a high rate of diabetes)

## **SPONSOR VERIFICATION**

I hereby certify *under penalty of licensure action and other liability for fraudulent claims* that the information provided on this application 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 Visa Waiver Site Application to discount payment fees for uninsured patients with household incomes at or below 200 percent of the Federal Poverty Level.

Sponsor Name:

Employer's Signature:

Title:

Date: \_\_\_\_\_

