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DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Public Health
Statutory Authority: 16 Delaware Code, Section 122 (1), (3)a & 11(8)
(16 Del.C. §122 (1), (3)a & 11(8))

4110 Conrad State 30/J-1 Visa Waiver Program

1.0 PURPOSE

This document will specify the procedures to be used by the Delaware Health and Social Services (DHSS) in administering the Conrad State 30/J-1 Visa Waiver Program (Program).

2.0 BACKGROUND

International medical graduates (IMG) completing their graduate medical education in the United States under a J-1 Visa are required to return to their country of nationality for at least two years before reentering the United States. Acting as an interested state agency, DHSS may make a recommendation to the U.S. Department of State, Bureau of Consular Affairs Waiver Review Division (DOS) to, in turn, recommend that the U.S. Citizenship and Immigration Services (UCIS) waive the home residence requirement for up to thirty (30) J-1 physicians annually (this includes five J-1 flex waivers to be used in areas that are not federally designated as a Health Professional Shortage Area (HPSA)), but nevertheless have been identified by the state as being underserved. In order to receive a letter of support for the J-1 physician applicant from DHSS, however, applications must first meet requirements, described herein.

3.0 POLICY STATEMENTS

3.1 DHSS is committed to ensuring that quality health care is available to all residents of the State of Delaware. In an effort to ensure adequate medical services are provided in underserved areas, DHSS has elected to take advantage of the Conrad State 30/J-1 Visa Waiver Program.

3.2 Under this program, DHSS has established state-specific procedures that require sponsoring sites to submit a Site Application. This application consists of 1) a needs assessment, 2) proof that the sponsoring site has unsuccessfully attempted over a six month period to hire a physician with United States citizenship, 3) three letters of support from community leaders and/or leaders without financial interest in the practice site who reside in the practice site's service area, 4) strategy for long-term and short-term retention, 5) sponsoring site waiver agreement, 6) non-refundable processing fee of \$200, and 7) a site application form.

3.3 The needs assessment must establish and document that a particular need exists within the sponsoring site's service area before the site will be approved to hire a J-1 physician

recommendations. Applications must be processed in the best interest of the health care needs of Delawareans.

5.0 APPLICABILITY

5.1 These procedures apply to the following:

- All J-1 physicians seeking a J-1 visa waiver under PL 103-416 for employment in Delaware.
- All sponsoring sites seeking approval to hire a J-1 physician under the J-1 Visa Waiver program.
- All DHSS employees processing J-1 visa waivers under PL 103-416.

6.0 APPLICATION PROCESS

6.1 Sponsoring Site Pre-Approval Application Requirements

The Site Application (see Appendix A for Application forms) must, at a minimum, include the following:

6.1.1 Site Application Form

6.1.1.1 **Sponsoring Site:** Provide the name, address, county, telephone number, fax number and the e-mail address of site requesting approval to hire a J-1 physician. Also, the site must specify whether it is a for-profit or not-for-profit business.

6.1.1.2 **Practice Site:** Provide the name, address and county of actual practice site(s) where the requested J-1 physician would practice, if different from the primary location of the sponsoring site.

6.1.1.3 **Recruitment Contact:** Provide the name, address, county, telephone number, fax number and e-mail address of the individual responsible for physician recruitment.

6.1.1.4 **Site Data Regarding Active Clients:** Provide the total number of active patients at the practice site in the previous calendar year. Indicate total patients, as applicable, for primary care, specialty care and mental health services. Provide pro-rated or estimated annual totals if the site was not operational for the entire previous calendar year. For new sites, estimate the number of patients anticipated for the next year. Of the total number of patients, provide the percentage of all current patients, broken out by given age groups, making payment by conventional insurance plans, Medicare, Medicaid or on a sliding fee scale. A copy of the sliding fee scale must be submitted.

6.1.1.5 Sites approved to participate in the Conrad State 30/J-1 Visa Waiver Program must also participate in state programs for the uninsured/under insured such as the Community Healthcare Access Program (CHAP), the VIPII provider network, and, if

appropriate other charitable programs. Sponsoring sites must verify that they will enroll in the VIPII Program within 30 days of site approval (if they are not already network members). To enroll in the program, call Wheeler and Associates at 302-335-1560.

6.1.1.6 Staffing Levels: Provide the total number of budgeted full-time equivalent providers currently on staff. Also include the number of J-1 physicians requested, by specialty, and the projected hire date of each.

6.1.1.7 Practice Site Hours of Operation: Indicate the normal operating hours of the practice site(s) by the days of the week. If hours of operation vary by practitioner, please specify.

6.1.1.8 Proposed J-1 Physician Weekly Work Schedule: Indicate the proposed weekly work schedule of the proposed J-1 physician(s). Include the number of hours (with start and end times) and the location (hospital/practice site(s)). The schedule must indicate the amount of time the J-1 physician is actually providing services; do not include travel or on-call time.

6.1.2 Needs Assessment

Sponsoring sites are encouraged to work with their local hospital to complete the needs assessment. A comprehensive, data driven needs assessment must be completed, which, at a minimum, includes the following:

6.1.2.1 Description of the service area in which the sponsoring site's patients are located.

6.1.2.2 Geographic Service Area Health Resource Inventory. Description of the other health care resources located within the same service area including physicians (by specialty), hospitals, clinics, urgent care centers and any other available outpatient care facilities. Also include the location of the nearest available source of outpatient based services, which offers a sliding fee scale to patients with limited financial resources and that provides services similar to those that are being provided by the requested J-1 physician. Using public transportation as the mode of travel, indicate the distance and travel time to that site.

6.1.2.3 Documentation that the sponsoring site's service area is located within a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA). Please indicate the following: HPSA Type(s), HPSA Service Area Number, HPSA FIPS State/County Code and the sponsoring site's primary service area (by City/County).

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

- Provide statistics demonstrating the need for a specialty and/or sub-specialty in the sponsoring site's service area.
- Document that the specialty and/or sub-specialty is not available to the underserved population in the service area.
- Describe how a J-1 physician would be used to meet the needs of the underserved population in the service area. Indicate if unique qualifications, such as cultural

match or experience with the service area's underserved population, are sought to meet a particular need.

6.1.3 Retention

The sponsoring site must provide *thorough*, written documentation of plans to retain the J-1 physician in the service area upon completion of the three-year practice obligation. Specifically, this plan must include short and long-term strategies that will not only keep the physician in the service area, but also will encourage the physician to continue to practice the specialty for which he/she was hired including but not limited to malpractice insurance, partnership opportunities, if applicable, annual and sick leave, competitive salary and salary increases and a health and/or benefits package. The employment contract may not contain any Restrictive Covenants or Non-Compete Clauses.

6.1.4 Contract

6.1.4.1 The employment contract that will be offered to the J-1 physician(s) must be submitted for review to the J-1 Board and at a minimum, include the following:

- Name and address of the sponsoring site.
- Name and address of the location of the sponsoring site's practice. If the J-1 physician will work at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the physician will practice at each site.
- A statement that the J-1 physician will work not less than four days per week or more than 12 hours in a 24 hour period. The hours must be performed during normal office hours or hours which best meet the needs of the community (e.g. evenings and/or weekends). Travel and on-call time can not be included.
- A statement that the site will employ the physician on a full-time basis (minimum of 40 hours per week, not including time spent in travel and/or on-call).
- Statement that the J-1 physician will commence practice within 90 days of receiving a waiver and will practice on a full-time basis for at least three years.

6.1.4.2 The employment contract may not include a restrictive covenant or non-compete clause.

6.1.5 Proof of Failed Recruitment Attempts

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, medical journal and newspaper advertisements, letters to medical residency programs and/or medical schools, etc. Please state any attempts to gain recruitment support from the hospital within the practice site's geographic service area, and if applicable, indicate effort to use the Delaware State Loan Repayment Program, the National Rural Recruitment and Retention Network (3R Net), and the National Health Service Corp. to recruit a US citizen.

6.2.2 The J-1 Physician Application (see Appendix C for application forms) must, at a minimum, include the following:

6.2.2.1 Letter from the Director of the Sponsoring Site

The director of a pre-approved sponsoring site must submit a letter requesting a Delaware Health and Social Services (DHSS) recommendation to the U.S. Department of State, Bureau of Consular Affairs Waiver Review Division (DOS) (or other Federal approving agency) that a J-1 physician be given a waiver of the requirement to return to their country of nationality. The letter must include, or attach, each of the following:

- Description of the J-1 physician's qualifications, proposed responsibilities and how his/her employment will meet the unmet health care needs of the medically underserved community.
- If the J-1 physician will be practicing in a HPSA or MUA that is based on a population group, the employer must provide adequate documentation of the medical care that will be provided to this group of patients.
- Confirmation that the sponsoring site and the J-1 physician participates in or applied to participate in the VIPII Program. J-1 physicians must apply to participate in the program within 30 days of executing an employment contract with a sponsoring site. To enroll in the program, call Wheeler and Associates at 302-335-1560. Once enrolled, the VIPII program manager will notify the J-1 Program manager.
- Certification that the J-1 physician will provide medical 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). Enclose a copy of the sliding fee scale or policy for discounting charges.
- Completed Physician Data Sheet (copy enclosed).
- Copy of the J-1 physician's curriculum vitae (CV).
- Evidence of eligibility for a Delaware medical license.
- At least three letters of recommendation from persons familiar with the J-1 physician's work.
- A signed statement from the J-1 physician agreeing to the contractual requirements set forth in Section 214 (k)(1) (B) and (C) of the Immigration and Nationality Act.
- Copies of all IAP-66 forms issued to the J-1 physician seeking the waiver.

6.2.3 Employment Contract

6.2.3.1 The employment contract must be submitted for review to the J-1 Board and at a minimum, include the following:

- Name and address of the sponsoring site.

- Name and address of the location of the sponsoring site's practice. If the J-1 physician will work at more than one site, include the days and hours of practice at each site and a breakdown in the amount of time the physician will practice at each site.
- A statement that the J-1 physician will work not less than four days per week or more than 12 hours in a 24 hour period. The hours must be performed during normal office hours, or hours which best meet the needs of the community (e.g. evenings and/or weekends). Travel and on-call time can not be included.
- A statement that the site will employ the physician on a full-time basis (minimum of 40 hours per week, not including time spent in travel and/or on-call).
- Statement that the J-1 physician will commence practice within 90 days of receiving a waiver and will practice on a full-time basis for at least three years.
- The employment contract may not contain any Restrictive Covenants or Non-Compete Clauses.
- It must include a competitive salary.
- Personal time such as vacation and sick leave must be specified.
- A breakdown of all proposed benefits must be provided.

6.2.4 Letter of No Objection from Home Country

6.2.4.1 A statement that the physician's home country has no objection to the physician receiving a waiver of the foreign residence requirement must be included if the J-1 physician received funding from his or her home country for medical education or training in the United States. The Certification Regarding Contractual Obligation to Home Country (HD1061F) letter must be submitted directly to the following address by the J-1 physician applicant:

Waiver Review Division
 Department of State
 Bureau of Consular Affairs, Visa Office
 CA/VO/L/W Room, L603
 2401 E Street, NW
 Washington, DC 20522-0106

6.2.4.2 A copy of this letter must be included in the application packet.

6.2.5 Submission of Payment of the Department of State 'User Fee Required for Waiver Processing'

6.2.5.1 The J-1 physician applicant must provide proof that the \$215.00 processing fee has been sent to the DOS. A copy of the payment (i.e. check or money order) is considered sufficient proof. DHSS will not handle the submission of this fee. The fee must be mailed directly to the DOS at the time the J-1 Visa Waiver Application packet is submitted to DHSS. The submission of the fee must adhere to the following requirements:

- A copy of the Physician Data Sheet and two self-addressed, stamped, legal-size envelopes must accompany the \$215.00 DOS user fee. The applicant's full name, date of birth and social security number must be included on the check or money order, which must be drawn on a bank or other institution located in the United States and made payable to the United States DOS in U.S. currency. If the applicant resides outside the U.S. at the time of application, remittance may be made by bank international money order or foreign draft drawn on an institution in the U.S. and made payable to the United States DOS in U.S. currency. The envelopes will be used to inform the applicant of 1) the case number, which must be included on all future correspondence with DOS, and 2) the approval determination.
- The address to which you must submit these items follows, depending on whether the United States Postal Service or a Courier Service is selected:

If Sending Via United States Postal Service:

US Department of State
 Waiver Review Division
 Post Office Box 952137
 St. Louis, MO 63195-2137

If Sending Via Courier Service:

US Department of State
 Waiver Review Division (Box 952137)
 1005 Convention Plaza
 St. Louis, MO 63101-1200

6.2.6 J-1 Visa Waiver Statements

The J-1 physician applicant must sign and include the enclosed 'J-1 Physician Waiver Statements.'

6.2.7 J-1 Visa Waiver Affidavit and Agreement

The J-1 physician applicant must include a notarized 'J-1 Visa Waiver Affidavit and Agreement.' The document must contain the J-1 physician applicant's live, notarized signature (in blue ink).

6.2.8 J-1 Visa Waiver Application Checklist:

The enclosed checklist must accompany the application. The J-1 physician applicant must initial each item on the checklist as proof and assurance that each item is included in the waiver application packet.

6.2.9 Non-refundable \$250 processing fee

6.2.9.1 A non-refundable processing fee of \$250 shall be charged to each pre-approved site to process the waiver request application for each J-1 physician that the site plans to employ. The check will be made payable to the State of Delaware and mailed to the following address:

7.3.2 Using the Site Application Evaluation (see Appendix D for the form) as a guide, Board members must assign a score to each of the elements on the Site Application Evaluation form.

7.3.3 The following point scale has been assigned to each unique element:

Review Point Scale

Site Application Data	25
Needs Assessment	35
Retention	15
Proof of Failed Recruitment Attempts	15
Letters of Support	10
<hr/>	
Total	100

7.3.4 The scores from the review elements will be averaged to reach an overall total score for each Board member. The total scores received from each Board member will then be averaged to determine the final score for each site.

7.3.5 Sites will be approved only if:

7.3.5.1 All criteria are met,

7.3.5.2 A final score not lower than a 70 is achieved, and

7.3.5.3 An overall score of at least a twenty-five (25) is achieved on the Needs Assessment component.

7.4 Timelines

Pre-approved sponsoring sites (whose applications were received by June 30) will be eligible to make a contractual offer to a J-1 physician for the following federal fiscal year (beginning October 1st of each year). However, if not all thirty Conrad State 30/J-1 Visa Waiver slots have been used for the current federal fiscal year, pre-approved sponsoring sites may make a contractual offer to a J-1 physician for the current fiscal year and the physician may submit a J-1 visa waiver application packet (see Appendix C for forms) immediately.

7.5 Guidelines for Review of Applications Submitted After June 30

7.5.1 Applications received after the June 30 deadline will be reviewed to determine if an emergent need (see Glossary for definition of emergent) for the placement of a J-1 physician is demonstrated. The application must include a detailed explanation that documents why the application was not submitted by June 30. If not all thirty Conrad State 30/J-1 Visa Waiver slots have been used for the current fiscal year, sponsoring sites deemed by the J-1 Board to have sufficiently demonstrated a true emergent need may make a contractual offer to a J-1 physician immediately upon approval and the physician may submit a J-1 visa waiver application packet (see Appendix C for forms) for the current fiscal year. If all thirty Conrad State 30/J-1 Visa Waiver slots have been used, then approved sponsoring sites must wait until the following federal fiscal year (beginning October 1st of each year) to submit a J-1 physician waiver application.

14.0 J1 VISA WAIVER APPLICATION GLOSSARY

Department of State, Bureau of Consular Affairs Waiver Review Division (DOS)

The Federal agency that reviews the recommendations submitted by interested state agencies on behalf of J-1 physician applicants. In turn, they submit their own recommendation to the Immigration and Naturalization Service for final determination of approval/disapproval.

Emergent Need

An emergent need is one that demonstrates an unusual and critical need for the placement of a J-1 physician, such as the death, unexpected departure, or sudden retirement of a clinical physician providing a majority of medical care needs at the sponsoring site.

Health Professional Shortage Area (HPSA)

An area defined by the Department of Health and Human Services as having a shortage of health care providers.

J-1 Physician

An international medical graduate physician completing graduate medical education in the United States under a J-1 Visa. These physicians are required to return to their country of nationality for at least two years before reentering the United States *unless a J-1 Visa waiver is granted*.

Medically Underserved Area

An area, as defined by the Department of Health and Human Services, as not having an adequate supply of health care providers.

Practice Site

Actual physical location(s) at which the J-1 physician will provide medical services. This location can be different from the sponsoring site location if, for example, a satellite office is used.

Primary Care Fields

The following four fields are identified as primary care: family practice, general internal medicine, general pediatrics and obstetrics/gynecology.

Processing Fee

The Bureau of Health Planning and Resources Management within the Delaware Division of Public Health shall charge a non-refundable processing fee of \$200 to each sponsoring site submitting a Site Application at the time the application is submitted. A non-refundable processing fee of \$250 shall be charged to each pre-approved site to process the waiver request application for each J-1 physician that the site plans to employ. The check will be made payable to the State of Delaware.

Recruitment Contact

Primary point of contact to be used by Delaware Health and Social Services Conrad State 30 Program Manager.

Service Area

Geographic area in closest proximity to the practice site, from which the majority of patients are derived.

Sponsoring Site

Medical practice through which the J-1 physician will provide medical services (i.e. the hiring organization).

Doc # 35-05-20/07/04/09



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

SITE APPLICATION FORMS

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

APPENDIX A

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

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		TOTAL HOURS
	(Start and End)		
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 J-1 PHYSICIANS REQUESTED	PROJECTED HIRE DATE			
	CURRENT		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 J-1 PHYSICIANS REQUESTED	PROJECTED HIRE DATE			
	CURRENT		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						
Clinic Marriage and Family Therapists						

What are the practice hours of this facility?

DAY	TIME (Start and End)		TOTAL HOURS
	AM:	PM:	
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 J-1 PHYSICIANS REQUESTED	PROJECTED HIRE DATE			
	CURRENT		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 County 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 County 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 County 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 County 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.

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.

	<p>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.</p>
	<p>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</p>
	<p>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.</p>
	<p>I agree to adhere to all provisions of these regulations, including the contract provisions (see VII. D. Contract)</p>

VII. SIGNATURE

Signature of Applicant Official: _____

Title: _____ Date: _____

Printed or Typed Name: _____



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

J-1 PHYSICIAN 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

DELAWARE HEALTH AND SOCIAL SERVICES
J-1 PHYSICIAN WAIVER STATEMENTS

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' 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. I 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 me 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

<u>Review Element</u>	<u>Possible Weight</u>	<u>Assigned Points</u>	<u>Comments</u>
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		



DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

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		TOTAL HOURS
		(Start and End)		
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		TOTAL HOURS
		(Start and End)		
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: _____