



J-1 VISA WAIVER PROGRAM GUIDELINES/APPLICATION PROCESS

Purpose: The Department of Health (DOH) State Primary Care Office (PCO) administers the Conrad State 30/J-1 Visa Waiver Program. Our goal is to improve access to health care services, and to address health disparities, within federally designated health professional shortage areas (HPSAs) and medically underserved areas/populations (MUAs/MUPs).

General Guidelines:

- Up to 30 waivers will be recommended from October 1 through September 30 of each year (cycle).
- Applications must receive a minimum score of **45** in order to be recommended for a waiver.
- A physician must practice clinical medicine in a HPSA or MUA/P (excluding FLEX waivers) for the required three (3) year obligation period.
- Employment must be full-time (not less than 40 hours a week) of clinical services.
- A transfer from one site to another is not permitted without prior written approval by DOH.
- The **facility**, upon recommendation of waiver application, must: accept Medicaid/Medicare clients; employ a discounted/sliding fee schedule for low-income clients; and post a notice in a conspicuous place in the waiting area that all clients will be seen regardless of their ability to pay.
- There is no limit to the number of applications submitted by an employer. However, only one application per specialty may be recommended. If unused slots remain, additional applications from like specialties may be considered. The employer will prioritize the applicants from like specialties based on their clinic needs.
- There are no restrictions regarding the type of specialists allowed, with the exception of those involved in care that is not medically essential, such as, cosmetic surgery.
- Past compliance with the program guidelines may be considered.
- ***Of the 30 waivers, 5 are available for specialists.*** Additional waivers for specialists will be considered if there are unused waivers after the review and scoring process is complete.
- ***Non-HPSA-MUA/P (FLEX) waivers*** will be considered **ONLY** if there are unused waivers after the review and scoring process is complete. Only those applications received by the established deadline will be considered.

Procedures for Submission and Review of Applications

The deadline for submitting applications is the ***first Monday in November*** of each year. Applications will be accepted each cycle through the end of the business day on the established deadline; applications received after the deadline will not be considered.

Applications will be reviewed competitively and final determinations will be made on the basis of the eligibility requirements and selection criteria specified. Applicants will be notified of the decision to recommend or not recommend their application. Recommended applications will be sent certified mail, return receipt requested to the United States Department of State (USDOS.)

Applicants will receive notification that the application has been forwarded. ***Applicants will be notified directly from the USDOS of their approval/denial. DOH approval does not guarantee approval from the USDOS or the Bureau of Citizenship and Immigration Services.***

The following is a list of documents to be submitted. Submit **one original and one copy** of the completed application and required documents.

IMPORTANT

The United State Department of State waiver case file number must appear on the lower right corner on every page of the application.

- 1) Completed Florida J-1 Waiver Application (including J-1 Physician Waiver Affidavit)
- 2) Letter From Facility that indicates a desire to hire physician and recruitment efforts.
- 3) Data Sheet DS-3035 (<http://travel.state.gov/pdf/ds3035.pdf>)
- 4) Employment Contract Requirements
 - The physician and the head of the health care facility must sign the contract
 - The date that the contract is signed should be included in the contract
 - The name and street address of the health care facility, and the specific geographical area(s) in which the physician will practice medicine
 - A minimum of 40 hours weekly to provide direct patient care
 - A three-year term
 - A statement from the foreign medical graduate agreeing to the contractual requirements set forth in Section 214(1) of the Immigration and Nationality Act (sample language)

--The alien demonstrates a bona fide offer of "full-time" (40 hrs.) employment at a health facility and agrees to begin employment at such facility within 90 days of receiving such waiver and agrees to continue to work in accordance with paragraph (2) at the health care facility in which the alien is employed for a total of not less than 3 years only in the geographic area or areas, which are designated by the Secretary of Health and Human Services as having a shortage of health care professionals.

5) Physician Attestation (sample language)

I, _____, hereby declare and certify, under penalty of the provisions of 18USC.1001, that: (1) I have sought or obtained the cooperation of the _____ Department of Health which is submitting an IGA request on behalf of me under the Conrad 30 program to obtain a waiver of the two-year home residency requirement; and (2) I do not now have pending nor will I submit during the pendency of this request, another request to any U.S. Government department or agency or any equivalent, to act on my behalf in any matter relating to a waiver of my two-year home residence requirement.

6) Employer Attestation (sample language)

U.S. DEPARTMENT OF STATE EMPLOYER ATTESTATION
I, (name), (title), of (facility), hereby certify, under penalty of the provisions of 18 U.S.C. 1001, that our facility located at (address), (county), (FIPS code), (census tract); is located in a Health Professional Shortage Area (HPSA ID #); and provides medical care to Medicare and Medicaid eligible patients and indigent, uninsured patients.

Signature

Date

7) IAP-66/DS-2019 Forms must be submitted in chronological order with the “Beginning a new program” first.

8) Evidence of Shortage Designation Status.

9) Personal Statement from physician regarding his/her reasons for not wishing to fulfill the two-year home country residence requirement to which the FMG agreed at the time of acceptance of exchange visitor status.

10) Curriculum Vitae (J-1 physician).

11) Explanation For Out of Status *if* FMG spent any period of time in some other visa status, out of status, or outside of the US.

12) Form G-28 or letterhead from law office, if attorney represents applicant.

13) I-94 Entry and Departure Cards Photo copies, front and back.

14) A “No Objection” Statement from the visitor’s government *if* foreign government funding is involved.

<u>Send the complete application to:</u>	<u>For information, call or email:</u>
Department of Health State Primary Care Office J-1 Visa Waiver Program 4052 Bald Cypress Way, Bin C-15 Tallahassee, Florida 32399-1735	(850) 245-4444, Ext. *3848 Rae_Kelly@doh.state.fl.us

Monitoring and Reporting Requirements

Notification of waiver status and commencement of employment must be submitted to the Department of Health (DOH) upon receipt of written notification of approval from the Bureau of Citizenship and Immigration Service (BCIS). This notification must include the date the 3-year obligation commences.

The Department of Health (or representative) may conduct periodic monitoring of the J-1 visa waiver physicians and the practice sites through site visits, telephone calls or requests for written reports. Violation of any of the agreed upon conditions by the employer may result in denial of future requests for J-1 visa waivers. Violation of any of the agreed upon conditions by the physician may result in referral of the physician to the appropriate BCIS Office.

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

Other providers of indigent care in the community/county may be notified of the J-1 physician placement. The physician name and practice location may be posted on the DOH State Primary Care Office (PCO) website as a provider of primary health care that accepts Medicare, Medicaid and utilizes a discounted/sliding fee schedule for the uninsured population.

Contract changes which result in termination of employment, change in practice scope, and/or relocation from a site approved in the application request to a new site must be presented in writing to DOH PCO prior to the change.



J-1 PHYSICIAN WAIVER AFFIDAVIT

BEFORE ME, the undersigned authority, personally appeared _____, who after being duly sworn deposes:

1. My name is _____. I have requested the Florida Department of Health (DOH) to review my application for a waiver of the foreign residency requirement set forth in my J-1 Visa. By this review, I am requesting that the DOH recommend that the U.S. Citizenship and Immigration Service (USCIS) approve such a waiver of the residency requirement. I understand and acknowledge that the review of this request is discretionary and that in the event a decision is made not to recommend the waiver, I hold the State of Florida, DOH, its employees and/or any and all individuals or organizations involved in the review process harmless from any action or lack of action made in connection with this request.
2. I understand and acknowledge that a DOH recommendation to grant this request does not guarantee approval from the U.S. Department of State and/or the USCIS.
3. I further understand and acknowledge that the entire basis for the consideration of my request is DOH's voluntary participation and mission to increase the availability of medical care in areas designated by the Secretary of the U.S. Department of Health and Human Services as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps).
4. I understand and agree that in consideration for the granting of a waiver by the USCIS, I shall render medical care services to patients, including the underserved, for a minimum of forty (40) hours per week within a designated HPSA or MUA/P in Florida. Such service shall commence not later than 90 days after I receive notification of approval by the USCIS and shall continue for a minimum of three years.
5. 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 or Medicare. I will charge persons receiving services at the usual and customary rate prevailing in the HPSA or MUA/P in which services are provided, except persons at or below 200 percent of the federal poverty level as determined annually by Department of Health and Human Services shall be charged on a discounted or sliding fee schedule or shall not be charged if they are unable to pay for these services.
6. I expressly agree to provide written notification of the specific location and nature of my practice to DOH at the time I receive notification of the granting of the waiver from USCIS and at the time I commence rendering services in the HPSA or MUA/P. I further understand and agree that relocation from a site approved in the application request to a different site must be approved by DOH in writing prior to the relocation.
7. I agree to comply with the requirements set forth in Section 214(k) of the Immigration and Naturalization Act and to comply with all DOH J-1 Visa Program Monitoring and Reporting Requirements.
8. I further certify that my prospective employer will structure my employment and the operations of the health care facility to facilitate my compliance with the requirements of my waiver, if granted.

FURTHER AFFIANT SAYETH NAUGHT. _____

Sworn to and subscribed before me this _____ day of _____.

Notary Public

My commission expires:



J-1 VISA WAIVER PROGRAM APPLICATION

PLEASE TYPE OR PRINT CLEARLY

Please check appropriate box:			US Department of State Case Number
<input type="checkbox"/> Primary Care	<input type="checkbox"/> Specialist	<input type="checkbox"/> FLEX	<div style="border: 1px solid black; width: 150px; height: 20px; margin: 0 auto;"></div>

EMPLOYER (HEALTH CARE FACILITY)

ADDRESS	CITY	ZIP	COUNTY

CONTACT PERSON	TELEPHONE #	FAX #	EMAIL

CLINIC WHERE J-1 PHYSICIAN WILL PRACTICE (if different from above.) PLEASE LIST ALL LOCATIONS, IF MORE THAN ONE

NAME OF J-1 PHYSICIAN	HOME COUNTRY

PRACTICE SPECIALTY	DATE OF BIRTH

Documentation Required: Include J-1 physician's curriculum vitae/resume.

EMPLOYER TYPE:

Safety Net Provider (specify) _____
 Other Not For Profit
 For Profit

SERVICE TYPE:

Outpatient/Ambulatory
 Hospitalist
 Other (specify) _____

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

Primary Care	Specialty Care	Mental Health Care	Total

Provide a breakdown (number or percentage) of each of the following payor types by patient group for the previous calendar year.

Group	Medicaid	Sliding Fee	Uncompensated Care
Pediatric/Adolescent			
Adult			
Geriatric			

Does the health care facility have an existing discounted/sliding fee schedule? Yes No
If yes, include a copy with this application.

If yes, does the health care facility have a notice conspicuously posted of the availability of a discounted/sliding fee schedule? Yes No

If no, does the health care facility agree to implement a discounted/sliding fee schedule, as well as post the notice of availability? Yes No

Documentation Required: Submit a copy of the health care facility discounted/sliding fee schedule, along with a letter assuring a firm commitment by the employer to apply the discounted/sliding fee schedule. Submit a copy of the public notice of the availability of a discounted/sliding fee schedule. The public notice shall be posted in the patient waiting room and shall include the practice site's commitment to serve all patients regardless of their ability to pay or their enrollment in Medicare or Medicaid.

What is the facility's minimum fee for service? \$ _____

Does the employment contract contain a non-compete clause? Yes No

If this application is for a full-time specialist or for a FLEX (Non-HPSA-MUA/P) waiver, please complete the appropriate addendum.

 I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have not evaded or suppressed any information contained in this application or in any of the supporting materials.

 Signature

 Date

 Name (Printed)

 Title

SPECIALIST WAIVER ADDENDUM

Applicants submitting an application for a specialist waiver must demonstrate a need for that specialty by addressing the following:

	Points
1) Describe how the specialty is needed to address the leading cause(s) of mortality or a major health problem in the service area.	1-10
2) Describe who will benefit from the specialty services. Provide data on the number of patients affected and how many are low-income (Medicaid) or uninsured.	1-10
3) Provide the number of physicians practicing this specialty in the service area. If this specialty is currently not available in the service area, identify the nearest location where this specialty service can be obtained.	1-5

FLEX (NON-HPSA-MUA/P) WAIVER ADDENDUM

Applicants submitting an application for a FLEX waiver must demonstrate a need by addressing the following:

1) Describe the facility's service area. Provide evidence that a minimum of 30% of the employer's current patient base resides in a neighboring HPSA or MUA/P. (Ex. Patient visit report that identifies total patient visits in the last 6-12 months of service by patient origin zip code.)	1-10
2) Describe who will benefit from the physician's services. Identify the % of Medicaid and Medicare patients who will have access to this physician. Describe how the facility will assure access to this physician for low-income or uninsured patients.	1-10
3) Provide evidence the facility serves a disproportionate share of uninsured and/or Medicaid recipients (data on the number of patients affected and how many are low-income or uninsured).	1-10
4) If this service is not currently available in the community, identify the nearest location where this service can be obtained.	1-5



J-1 VISA WAIVER PROGRAM
SCORING CRITERIA *(for DOH Office Use Only)*

APPLICATION TYPE	<input type="checkbox"/> Primary Care	<input type="checkbox"/> Specialist	<input type="checkbox"/> FLEX
PHYSICIAN'S NAME _____	SPECIALTY _____		
EMPLOYER _____	CITY/COUNTY _____		
REVIEWERS INITIALS _____	DATE _____	TOTAL SCORE _____	

CRITERION 1 (WEIGHT X4)

HPSA TYPE

- GEOGRAPHIC.....5
- SPECIAL POPULATION.....3
- FACILITY.....2

Total *4 = _____

CRITERION 2 (WEIGHT X2)

HPSA SCORE

- HIGH (14 and above).....4
- MEDIUM (11-13).....3
- LOW (10 and below).....2

Total *2= _____

CRITERION 3 (WEIGHT X6)

TYPE OF EMPLOYER

- SAFETY NET.....5
- OTHER NOT FOR PROFIT.....3
- FOR PROFIT.....1

Total *6 = _____

CRITERION 4 (WEIGHT X3)

TYPE OF SERVICE

	OUTPATIENT/AMBULATORY.....	5
	HOSPITALIST.....	3
	OTHER.....	2

Total *3 = _____

CRITERION 5 (WEIGHT X3)

PATIENT MIX: Medicaid, Sliding Fee, Uncompensated Care

	>50%.....	5
	25%-49.9%.....	4
	10%-24.9%.....	3
	<10%.....	2

Total *3 = _____

CRITERION 6 (WEIGHT X2)

MINIMUM FEE FOR SERVICE

	</= \$20.....	3
	> \$20.....	2

Total *2 = _____

CRITERION 7 (WEIGHT X1)

NON-COMPETE CLAUSE

	NO.....	3
--	---------	---

Total *1 = _____

CRITERION 8 (WEIGHT X1)

CURRENTLY UTILIZING SLIDING FEE SCHEDULE (copy included)

YES.....3

Total *1 = _____

DEFINITIONS

Institutionalized

- Prison
- Hospice
- Nursing Home
- Psychiatric Hospital

Safety-Net Provider

- Federally Qualified Health Center (FQHC)
- FQHC Look-Alike
- County Health Department
- Community Mental Health Center
- Homeless Center
- Public University-Based Hospital/Clinic
- Rural and Critical Access Hospital and Associated Clinic
- State Correctional and Psychiatric Facility
- Certified Rural Health Clinic
- Section 766 Charitable Clinic

Primary Care

- Family Practice
- General Pediatric
- Obstetric/Gynecology
- General Internal Medicine
- Combined Internal Medicine/Pediatric
- Geriatric
- Infectious Disease
- Psychiatry
- Hospitalist