pennsylvania DEPARTMENT OF HEALTH

COMPLETE SHADED AREAS OF APPLICATION

H607.722 Rev. 06/11

PENNSYLVANIA DEPARTMENT OF HEALTH
BUREAU OF HEALTH PLANNING

J-1 VISA WAIVER PROGRAM
NATIONAL INTEREST WAIVER PROGRAM

DOH USE ONLY			
HPSA Name			
ID #		Desig Date	
Ratio			
MUA/MUP			
ID #		Desig Date	

SITE APPLICATION FOR WAIVER PROGRAMS

Complete a Separate Application for Each Practice Site.

This form will be used to evaluate a practice site for participation by Health Care Practitioners in the J-1 Visa and the National Interest Waiver Programs.

Site Application is being submitted for:
- ☐ J-1 Visa Waiver
- ☐ National Interest Waiver

1. NAME OF PRACTICE SITE: _____

PHYSICAL ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE (9 digit) _____

TWP/BORO: _____ CENSUS TRACT: _____ COUNTY: _____

PHONE: _____ FAX: _____ EMAIL: _____

MAILING ADDRESS: (If different than physical address) _____

CITY: _____ STATE: _____ ZIP CODE (9 digit) _____

Days and hours at **this** site if multiple sites are proposed: _____

Type of Practice: *(select one)* ○ Public ○ Private Non-Profit ○ Private For Profit

Date Practice Opened: _____ If a new practice, list anticipated start date: _____

Type of Site: (check the most appropriate block)

BPHC-FUNDED	OTHER	OTHER (continued)
☐ CHC/MHC (329/330)	☐ HOSPITAL	☐ SOLO PRACTICE
☐ HOUSING PROJECT (340)	☐ HOSPITAL, FREESTANDING CLIN	☐ UNIVERSITY
☐ HOMELESS SHELTER (340)	☐ HOSPITAL, ON CAMPUS CLINIC	☐ CERTIFIED RURAL HEALTH CLINIC
☐ RYAN WHITE	☐ GROUP PRACTICE	☐ FQHC LOOK ALIKE

HEALTH DEPARTMENT

☐ COUNTY ☐ CITY

2. Discipline of Requested Physician ☐ FP ☐ IM ☐ Ped ☐ OB/GYN ☐ Psych ☐ Other: _____

Current # of physicians at site with same specialty: _____

3. SPONSORING ORGANIZATION NAME: _____

Type of Organization: *(select one)* ◯ Public ◯ Private Non-Profit ◯ Private For Profit

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____

PHONE: _____ FAX: _____ *(List 9 Digit Zip Code)*

EMAIL ADDRESS: _____

4. NAME OF PRACTICE SITE CONTACT: _____

TITLE: _____ PHONE: _____ FAX: _____

EMAIL ADDRESS: _____

5. List the ◯ Actual or ◯ Projected *(check one)* number of **active** users in the practice by source of payment for the site during the past calendar year for established sites or for the next calendar year if the site is not yet established. Active users is an unduplicated count of persons who have used the clinic at least once in the reporting calendar year. (Do not combine user numbers for other practice sites or combine other specialties if located at the same site, i.e., if the proposed practitioner is a pediatrician, only report pediatric users below.) The user numbers should be specific to the specialty listed in Question 2, Page 1. Both numbers and percentages must be listed. List all Medicaid HMO users in #2. List all non-Medicaid HMO users in #5. #3-Other is a category for users who cannot pay the full amount, but pay you something. #4-No Pay is for users you do not charge.

If you checked projected number of patients above, furnish information to substantiate projected number of patients for a 3 to 4 year period. If the practice site is located in a Low Income HPSA or MUP, complete the low income table attached.

	# of Active Users	% of Total of Active Users
1. Medicare		
2. Medicaid		
3. Other (Sliding Fee Scale)		
4. No Pay		
5. Full pay and commercial insurance		
TOTAL ACTIVE USERS IN PRACTICE:		

6. **CERTIFICATION:** I certify that the information provided in this application is true and correct as of the date set forth opposite my signature and certify that the practice site will abide by all the requirements for recruitment/retention assistance. I also understand that any intentional or negligent misrepresentation(s) of the information contained in this application may result in the forfeiture of our entity's eligibility to participate in this recruitment and retention program.

Entity agrees to cooperate with all policies and to cooperate with mail, electronic, telephone and/or site visits conducted by the Department of Health or its representatives for the purpose of monitoring compliance with the Loan Repayment Program or Waiver Programs.

_____ _____

PRINTED NAME AND SIGNATURE OF EXECUTIVE OR MEDICAL DIRECTOR DATE

PHONE: _____ FAX: _____ EMAIL: _____

Application Submission: Submit Site Application with the entire Waiver Packet

APPLICANT - DO NOT COMPLETE INFORMATION BELOW THIS LINE

Recommendation: ◯ Approve ◯ Disapprove

State Reason for Disapproval:

Name: _____ Title: _____

Phone Number: 717-772-5298

_____ _____

Signature Date

PRACTICE SITE PROFILE

Complete this profile only if you want the Department of Health to advertise your vacancy on our website.

Provide information to describe your employment opportunity such as: a description of your facility; services provided at site; current staffing; local hospitals; salary/benefits; and information about the community such as weather; industry/employment; educational institutions; recreation/leisure; etc.

Site Name:	
Description:	

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Low Income Table

Complete this table if the proposed practice site is located in a Low Income Health Professional Shortage Area (HPSA) or Medically Underserved Population (MUP). The data provided is used to evaluate the organization's services to the low-income population of the service area. We require that 30% of the site's patients be from the low income categories. To determine this, we use the Medicaid, Sliding Fee Scale, No Pay data listed below.

*Provide the number of patients below (not visits) in the specific categories. Count a patient in one category even though they may have supplementary insurance. Patients in Medicaid HMO's should be listed in #2. The data should be provided for the specialty you are requesting assistance with, i.e., recruitment of a family practice physician, and it should be site specific. Do not combine patient numbers for other specialties within the practice and do not combine patient data for other practice sites.

	Two Years Ago (Full 12 Months)	Previous Year (Full 12 Months)	Current Year (Year to Date)	Next Year Projected (For 12 Months)
1. Medicare				
2. Medicaid				
3. Sliding Fee Scale (This category is for patients who cannot pay the regular fee, but pay something)				
4. No Pay (Patients served who could not pay)				
5. Full Pay/Commercial Insurance/ HMOs				
***Total Number of patients served**				

Please describe how your staff handles calls from low income or uninsured individuals.

NOTICE

THIS PRACTICE HAS ADOPTED THE FOLLOWING POLICIES FOR CHARGES FOR HEALTH CARE SERVICES

We will charge persons receiving Health Services at the usual and customary rate prevailing in this area. Health Services will be provided at no charge, or at a reduced charge, to persons unable to pay for services. In addition, persons will not be charged for services to the extent that payment will be made by a third party authorized or under legal obligation to pay the charges.

We will not discriminate against any person receiving health services because of his/her inability to pay for services, or because payment for the health services will be made under Part A or B of Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act.

We will accept assignment under the Social Security Act for all services for which payment may be made under Part B of Title XVIII ("Medicare") of the Act.

We have an agreement with the State agency, which administers the State Plan for medical assistance under Title XIX ("Medicaid") of the Social Security Act to provide services to persons entitled to medical assistance under the plan.

SITE TO DISPLAY THIS COPY AT APPROVED PRACTICE SITES