Updated: 6/1/2020

pennsylvania
DEPARTMENT OF HEALTH

Practice Site Application

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

Waiver Type: Select One

Type of Site: Select One

Location of Setting: Select One

Profit Status: Select One

Designation Type: Select One

Designation Name: _____

Designation Number: _____

Discipline of Physician: Select One

Specialty: _____

Practice Site Information

Name of Practice Site: _____

Address: _____

City: _____ State: _____ Zip Code: _____ - _____

Twp/Boro: _____ Census Tract: _____ County: _____

Practice Site Contact: _____ Title: _____

Direct Phone Number: _____ Email: _____

Does this practice site have an existing discounted/sliding fee schedule and provide care to all patients regardless of their ability to pay? ☐ Yes ☐ No

Does this practice have a nominal fee less than $20.00 ☐ Yes ☐ No

Date Practice Opened: _____ Current number of physicians with same discipline: _____

What is the proposed schedule for the physician: _____day/week _____ hrs./week

Sponsor Information

Organization Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ - _____

Sponsor Contact: _____ Title: _____

Direct Phone Number: _____ Email: _____

Practice Site Application (Continues)

List the ☐ Actual or ☐ Potential (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. Both numbers and percentages must be listed. The other category is for users who cannot pay the full amount but pay something. No pay is for users you do not charge.

	# of Active Users	% of Total of Active Users
Medicare		
Medicaid		
Other (Sliding Fee Scale)		
No Pay		
Full pay and commercial insurance		
Total Active Users in Practice		

Complete the table below if the proposed practice site is in a **Low-Income Health Professional Shortage Area (HPSA) or Medically Underserved Population (MUP)**.

The data provided is used to evaluate the organization's service to the low-income population of the service are. 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 and No Pay data listed below.

Provide the total number of active patients 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 patients are unduplicated count of patients who have used the clinic at least once in the reporting calendar year.
Do not combine patient numbers for other specialties within the practice and do not combine patient data for other practice sites.

Source of Payment	**Previous Year (12 months)**	**Current Year (12 months)**	**Projected Year (12 months)**
Medicare			
Medicaid			
Sliding Fee Scale (This category is for patients who cannot pay the regular fee, but pay something)			
No Pay (Patient served who could not pay)			
Full Pay/ Commercial Insurance/HMOs			
Total Number of patients served			

Practice Site Application (Continues)

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 Waiver Program.

Print Name: _____ Date: _____

(Name of Executive or Medical Director)

Signature: _____ Title: _____

(Name of Executive or Medical Director)

Phone: _____ Email: _____