Michigan Department of Health and Human Services
FY2022 APPLICATION MICHIGAN CONRAD 30 J-1 VISA WAIVER PROGRAM

Physician Information

NAME OF J-1 PHYSICIAN	HOME COUNTRY	DATE OF BIRTH

PHYSICIAN'S SPECIALTY AS LISTED IN EMPLOYMENT CONTRACT	PHYSICIAN EMAIL ADDRESS

CHECK ONE:	CHECK ONE:	US DOS CASE FILE #:	LICENSE #:
☐ Primary Care ☐ Hospitalist ☐ Specialist	☐ Outpatient Based ☐ Inpatient Based		

DO YOU HAVE A SPOUSE APPLYING IN THIS APPLICATION CYCLE?	IF YES, PROVIDE THE FULL NAME
☐ Yes ☐ No	

Employer Information

NAME OF EMPLOYER

EMPLOYER ADDRESS	CITY	ZIP	COUNTY

EMPLOYER CONTACT (Not attorney)	TITLE

TELEPHONE #	FAX #	EMAIL

TOTAL # OF WORK SITES	PROJECTED START DATE

WORK SITE FORM

Use this form for each individual worksite. For multiple work sites, copy the form as needed.

NAME OF WORK SITE WHERE J-1 PHYSICIAN WILL PRACTICE	% OF TIME DURING THE 40 HR WORK WEEK AT THIS SITE

WORK SITE ADDRESS	CITY	ZIP	COUNTY

Is the site designated as a Safety Net Site*. If so, indicate which one below.

☐ State-funded Primary Care Clinic ☐ Certified Rural Health Clinic ☐ Local Health Department

☐ State Correctional Facility ☐ Critical Access Hospital ☐ Forensic Medicine Center

☐ Community Mental Health (CMH) Agency ☐ Federally Qualified Health Center

*Attach documentation to support the Safety Net Site designation. Refer to page 3 of the Program Guidelines under ***Definitions.***

HPSA # OR MUA/P#	HPSA SCORE	CENSUS TRACT #	RURAL OR URBAN

**For each worksite, please remember to attach the required documentation to support HPSA/MUA/MUP and the Rural/Urban Designation.*

REQUIRED FOR HOSPITALIST AND SPECIALIST APPLICATIONS - *complete one form for each work site.*
For multiple work sites, copy this form as needed.

NAME OF **WORK SITE**	% OF TIME DURING THE 40 HR WORK WEEK AT THIS SITE

List providers at the work site by specialty type and indicate percent of the time they serve at the work site. List only those providers in the **relevant** specialty and/or medical practice, not the entire facility/hospital medical staff.

SPECIALTY *List additional specialties as needed*	**NUMBER OF PROVIDERS**	**% OF TIME AT SITE**
FAMILY & GENERAL PRACTICE		
INTERNAL MEDICINE		
PEDIATRICS		
OBSTETRICS/GYNECOLOGY		
PSYCHIATRY		

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

PRIMARY CARE	SPECIALTY CARE	MENTAL HEALTH CARE	TOTAL

Provide a breakdown of each of the following payor types for the patients at the work site.

TOTAL # of PATIENTS	% MEDICAID	% MEDICARE	% SLIDING FEE/ SELF-PAY	% COMMERCIAL	% NO PAY/ WRITE-OFF

Provide a breakdown of the patient mix at the work site.

PATIENT TOTAL	% ADULT	% PEDIATRIC	% GERIATRIC (65 years or older)

Does the health care facility have an existing discounted/sliding fee schedule or provide care to all patients regardless of their ability to pay? ☐ Yes ☐ No

If yes, does the health care facility have a notice conspicuously posted of the availability of a discounted/sliding fee schedule or provision of care to all patients regardless of their ability to pay? ☐ Yes ☐ No

If no, does the health care facility agree to implement a discounted/sliding fee schedule or implement a policy to treat patients regardless of their ability to pay, as well as post the notice of availability? ☐ Yes ☐ No

***Recommended Documentation*:** 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.

HOSPITALIST AND SPECIALIST ADDENDUM

Note: Each response is limited to a 300-word maximum and must be entered into the text box (no additional materials). Please keep the completed form with the application (do not move it to the end, after the Rural/Urban report).

Applicants submitting an application for a Hospitalist or Specialist waiver must demonstrate a need for that physician specialty. Need is to be demonstrated by sufficient documentation that indicates the specialty is critical to the delivery of services in the community, the specialist is in high demand, and the specialist will serve the needs of the community's Medicaid, Medicare, and uninsured populations. Demonstrate a need for the specialty by addressing **one** of the following three need criteria:

1. **The physician specialty is needed to address a major health problem in the facility service area:**
   a. Identify the health problem and how the addition of specialty will address it.

   b. Describe the service area for this specialty and provide data on the number of patients affected, including how many are Medicaid beneficiaries, uninsured, or under-insured.

   c. Describe the availability of this specialty in the community and identify the nearest location where this specialty service can be obtained.

   d. Describe how the addition of this physician specialty will improve services and outcomes for the community.

OR

2. **The physician specialty is needed to address population-to-physician ratio because the current ratio does not meet national standards:**

a. Provide the population-to-physician ratio for the specialty, include source for data provided.

b. Provide the number of physicians (FTE) practicing this specialty in the same health professional shortage area/facility service area.

c. Provide the distance to the nearest physician practicing the same specialty.

d. Describe how the demand for the specialty has been handled in the past and how the addition of this provider will improve services and outcomes for the community.

OR

3. **The physician specialty is needed to meet state or federal health care facility regulations, for example to maintain the hospital trauma designation level:**

a. Identify the regulation.

b. Address how the facility is currently meeting this regulation.

c. Describe how the addition of this physician specialty will improve services and outcomes for the community.

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

Note: Each response is limited to a 300-word maximum and must be entered into the text box (no additional materials). Please keep the completed form with the application (do not move it to the end, after the Rural/Urban report).

Applicants submitting an application for a Non-HPSA-MUA/P waiver must demonstrate a need by addressing **all** of the following three need criteria:

1. Provide a summary of data describing that a minimum of 30 percent of the employer's current patient base resides in a neighboring HPSA or MUA/P.

2. Provide a summary of data demonstrating that the facility serves a disproportionate share of Medicaid beneficiaries, uninsured, and/or underinsured recipients (data on the number of patients affected and how many are Medicaid beneficiaries, uninsured, or underinsured).

3. If this service is not currently available in the community, identify the nearest location where this service can be obtained.

Applicant and Employer Signature

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.

Physician's Signature

Signature	Date
Name (Printed)	Title

Sponsoring Employer's Signature

Signature	Date
Name (Printed)	Title