Well-Ahead Louisiana Primary Care Office

Louisiana Conrad 30/J-1 Visa Waiver Program

# Site Information Form

*A separate form is required for each practice location at which the physician will regularly Practice*

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| Name and Address of Practice Site:  Name of Practice Site.  Address of Practice Site.  City/state/zip of Practice Site. | Name and Address of Employer (if different):  Name of Employer.  Address of Employer.  City/State/Zip of Employer. |
| Practice Contact Information:  Practice Contact Name and Title  Contact email address  Contact Phone Number | Employer Contact Information:  Employer Contact Name and Title  Contact email address  Contact Phone Number |
| Attorney for Employer:  E-Mail: Email address  Direct Phone Number: Phone number | Attorney for Physician:  E-Mail: Email address  Direct Phone Number: Phone number |
| Practice Type:  Public  Non-profit  For profit | Employer’s Medicaid ID #: |
| Service Site Type:  FQHC  RHC  Ambulatory Care Clinic  SBHC  SRH  CAH  Hospital  Other Click or tap here to enter text. | Employer’s Medicare ID #: Enter # here |
| Physician will practice:  Family Practice  General Internal Medicine  Pediatrics  OB/GYN  Psychiatry  Sub-specialty, specify type as advertised: Click or tap here to enter text. | |
| Specify the salary range for the physician exactly as it has been advertised, which must be 100% of the U.S. Department of Labor’s prevailing wage rate (level 2) for same type physician in the area and/or the same as the salaries of currently employed U.S. physicians of same type/experience at the practice site. **$**Click or tap here to enter text. | |
| What will be the work schedule for the physician? Include office hours, hospital privileges, call coverage, duties, patient load and an explanation of any special responsibilities for the position.  Click or tap here to enter text. | |
| How many total patients are seen at practice site yearly? Click or tap here to enter text. | How many of these patients are uninsured/ underinsured/qualify for sliding fee scale? Click or tap here to enter text. |
| How many of these patients are on Medicaid?  Click or tap here to enter text. | How many of these patients are on Medicare?  Click or tap here to enter text. |
| Does this practice site currently have in place a sliding fee scale/indigent care policy for patients below 200% of the Federal Poverty Level? Please check: YES  NO If yes, list the date the SFS Policy Implemented: \_\_\_\_\_\_\_\_\_\_\_  If yes, what percentage of uninsured/underinsured patients were eligible for reduced fees? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| How does the site ensure that patients are aware of the availability of the sliding fee scale/indigent care policy?  Please give details and provide examples of signage/notices in place at the site.  Click or tap here to enter text. | |
| Important Notes:   1. If a specialist position is being requested, complete and include the Dire Need Criteria form with all information requested at the time of this J-1 Visa Waiver request application. 2. If the site is not in a designated HPSA, but at least 30% of its patients are residents of a HPSA, or if it is located within a 30-minute drive time (20 to 25 miles) of a HPSA, the site can apply for one of ten non-HPSA **FLEX** slots available annually. Provide information (patient’s zip codes and/or maps showing distance to nearest HPSA) proving claim.   For additional Information, contact Yasmeen Mohammed at (225) 342-9306 or [Yasmeen.Mohammed@la.gov](mailto:Yasmeen.Mohammed@la.gov) | |
| Signature: | Date: |