

North Carolina Office of Rural Health National Interest Waiver (NIW) Guidelines

The physician must:

1. Work full-time (40 hours per week) in a clinical practice located in a Health Professional Shortage Area (HPSA) as defined by the United States Public Health Service within the State of North Carolina for **five** years (not including time in J-1 nonimmigrant status).
2. Practice full-time (40 hours per week) in a primary care specialty (family or general medicine, general internal medicine, pediatrics, obstetrics/gynecology or psychiatry). In addition to primary care physicians, medical specialists who agree to practice in a HPSA as having a shortage of health care professionals may be eligible for the physician national interest waiver under section 203(b)(2)(B)(ii) of the Immigration and Nationality Act.
3. Practice in the public interest. In North Carolina, this is defined as serving underinsured or uninsured patients as evidenced by acceptance of Medicaid, Medicare and use of a sliding/discount fee scale for those without insurance.
4. Sign and adhere to the North Carolina Office of Rural Health National Interest Waiver Affidavit and Agreement.

Procedures

A physician requesting an attestation letter from the North Carolina Office of Rural Health must complete the NIW Application. The physician will be notified in writing of the approval or denial of the request. If the request is approved, an attestation letter will be provided to the physician. If denied, a letter will be provided outlining the reason(s) the request was not approved.

Submit the completed application, required documentation and NIW Physician Agreement to:

North Carolina Office of Rural Health
311 Ashe Ave
2009 Mail Service Center
Raleigh, N.C. 27699-2009

For information:

Main Office: (919) 527-6440
Karen Gliarmis, Recruiter: (919) 527-6452
Email: karen.gliarmis@dhhs.nc.gov

Monitoring and Reporting Requirements

North Carolina Office of Rural Health (NCORH) will conduct periodic monitoring of physicians receiving attestation letters for a National Interest Waiver (NIW) 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, H1B physician transfers and NIW attestation letters. Violation of any of the agreed upon conditions by the physician may result in consequences; such as the termination of this agreement, a noncompliance report to US Citizenship & Immigration Services (USCIS), and/or the ineligibility of the employer and/or physician for future placements.

The physician and employer must submit the Statement of Service Form (Attachment 1), found on Pages 3-4 to NCORH. The Statement of Service Form assures that the sponsoring employer and the physician are complying with the requirements of the program. **The first Statement of Service Form must be submitted within 30 days after employment begins, and annually thereafter, until the five (5) year commitment is complete.**

The physician and/or employer is required to grant NCORH representatives, who shall maintain full confidentiality, reasonable access to all records maintained by the physicians' practice which are pertinent to ascertaining compliance with these guidelines, including, but not limited to, patient files and payment records. From time to time, audits for compliance of these guidelines may be performed by NCORH representatives.

Other primary care providers of indigent care in the community/county will be notified of the NIW physician placement.

Contract changes which result in termination of contract, 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 NCORH at least 30 days prior to the change.

North Carolina Office of Rural Health

STATEMENT OF SERVICE FORM

for

National Interest Waiver Attestation Letter Recipients

1. Participant's Name:

Practice Specialty:

2. Home Address:

3. Email:

4. Employer:

5. Contact Person, Phone # and Email:

6. Practice Name & Site Location (Street Address): *If the physician will be working in more than one facility/practice sites, provide a list of all physical locations as an attachment to this form.*

7. Practice Phone # (Area Code/Number):

8. Reporting Period: From

To

9. Obligation Period: From

To

10. Average number of hours worked per week at approved practice: _____

11. Average number of hours worked per week in hospital: _____

12. Average number of hours worked per week in other practice settings:

Home _____ Nursing Home _____ Other _____

13. Number of weeks absent from approved practice due to illness, vacation, or continuing education during this reporting period: _____

14. Does your practice accept assignment on all Medicare visits? Yes ___ No ___

15. Does your practice accept assignment on all Medicaid visits? Yes ___ No ___

By my signature, I pledge that the above answers are truthful and supplied to the best of my knowledge and ability.

Signature: _____

Date: _____

Employer Certification: I hereby acknowledge that all information and statements contained herein are true and do not misrepresent fact. I further acknowledge that I have complied with the NIW requirements.

Employer Signature

Date

Employer Name (PRINTED)

Title

Attachment 1

North Carolina Office of Rural Health

NATIONAL INTEREST WAIVER AFFIDAVIT AND AGREEMENT

I, _____, first being duly sworn, hereby request the North Carolina Office of Rural Health ("NCORH") to review my application for the purpose of issuing a Public Interest Attestation Letter.

1. I understand and acknowledge that the review of this request is discretionary on the part of NCORH and that in the event a decision is made not to grant my request, I shall hold harmless the NCORH and any and all its employees, agents and assigns from any and all liability whatsoever arising out of NCORH's action or lack of action in connection with this request.

2. I further understand and acknowledge that the entire basis for the consideration of my request is the NCORH policy and desire to improve the availability of medical care in regions designated as Health Professions Shortage Areas ("HPSA") in the State of North Carolina.

3. I understand and agree that in consideration for a Public Interest Attestation Letter which eventually may or may not be given, I shall render medical care services to patients, including the indigent, for a minimum of forty (40) hours per week within a designated HPSA located in the State of North Carolina. Such service shall commence not later than ninety (90) days after I receive work approval by the United States Citizens and Immigration Services (USCIS) and shall continue for a minimum of five (5) years or longer from latter of either the USCIS work approval date or my employment start date in the State of North Carolina.

4. I agree to incorporate all the terms of this National Interest Waiver Affidavit and Agreement into any and all employment agreements I enter into pursuant to Paragraph 3 above and I shall include in each such employment agreement(s) the attached National Interest Waiver Affidavit and Agreement. A copy of all current employment agreements shall be attached hereto. My transfer to any other qualifying site(s) within the State of North Carolina shall be approved in advance by the NCORH

5. I further agree that any employment agreement I enter into, pursuant to Paragraph 3 above, shall not contain any provision which conflicts with, modifies or amends any of the terms of this National Interest Waiver Affidavit and Agreement.

6. I also agree to incorporate all terms of this National Interest Waiver Affidavit and Agreement into any employment agreement(s) I enter into pursuant to Paragraph 3 above.

7. I understand and agree that I will 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 Medicare or Medicaid.

8. I expressly understand that the granting of a national interest waiver must ultimately be approved by the USCIS and, therefore, I agree to provide written notification of the specific location and nature of my practice to the NCORH contact person at the time I receive notification of USCIS approval and I commence providing services in the State of North Carolina.

9. I understand and acknowledge that if I willfully fail to comply with the terms of this National Interest Waiver Affidavit and Agreement, engage in any falsification, omission or misrepresentation of the information in this NIW, then these actions shall render this agreement and the physician's
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placement null and void; the physician will have failed to meet the service requirement and NCORH will notify the USCIS. Additionally, any and all other remedies available to the NCORH, will be undertaken in the event of my breach of the terms of this National Interest Waiver Affidavit and Agreement.

I declare under penalty of perjury that the foregoing is true and correct.

BY: _____

Printed Name: _____

Date: _____

Sworn to and subscribed before me this ____
day of _____, 20____.

(Notary Public)

My Commission expires: _____

ACCEPTED BY: _____
NCORH

DATE: _____

North Carolina Office of Rural Health
National Interest Waiver
APPLICATION

NIW PHYSICIAN	HOME COUNTRY	DATE OF BIRTH	PRACTICE SPECIALTY
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ADDRESS	CITY	ZIP
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TELEPHONE #	NPI #	EMAIL
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Documentation Required: Include NIW physician's curriculum vitae (CV) and North Carolina medical license or license application receipt from the North Carolina Medical Board.

HEALTH CARE FACILITY	TELEPHONE #	EMAIL
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ADDRESS	CITY/ COUNTY	ZIP	HPSA ID #
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Documentation Required: Include a narrative about the scope of practice. If this is a relocation, include the reason(s) for the relocation.

1. Date employment began (if already at facility): _____

2. Placing authority for the original J-1 Visa Waiver (if applicable):

State 20 USDA Other (Specify) _____ Original Visa was H1B

3. The health care facility is (check all that apply):

For-Profit Non-Profit Government Organization Community Health Center

Public Hospital District Other Publicly Funded Provider (Specify) _____

Other (Specify) _____

_____ Shortage area ID# and 9-digit zip cod

4. Please note the percentage of total patient visits from the preceding 12 months that the health care facility provides to each of the following populations:

Medicaid _____% Discounted/Sliding Fee _____%

Medicare _____% Uncollectable/Write-off _____%

Documentation Required: Submit a report or other documentation that supports the information provided above, **INCLUDE MEDICAID PROVIDER NUMBER**. North Carolina's guidelines require that the health care facility serve Medicare, Medicaid, low-income and uninsured clients. If this position will be filled in a new location/expansion of the existing facility, use the data from the existing facility.

5. Practice Site Hours of Operation

DAY	TIME (Start and End)		TOTAL HOURS
	AM:	PM:	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

6. Proposed NIW Physician Weekly Work Schedule (If more than one clinic location, provide schedule for each)

DAY	TIME (Start and End)		TOTAL HOURS
	AM:	PM:	
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

7. Does the health care facility have an existing discounted/sliding fee schedule?

Yes No

If no, does the health care facility agree to implement a discounted/sliding fee schedule?

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.

8. Does the health care facility have a notice conspicuously posted of the availability of a discounted/sliding fee schedule? Yes No

Documentation Required: 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.

9. Is a letter or contract from the health care facility (employer) indicating the desire to hire the NIW physician included? Yes No

Documentation Required: Documentation must be provided which indicates the health care facility's desire to hire the NIW physician. The documentation must include: a) the address of clinic where the NIW physician will be providing services (if more than one, please indicate each); b) a statement that employment will be for a minimum of 40 hours per week (full-time) providing medical care; c) salary to be paid the NIW physician; and d) statement regarding non-compete clause. Sponsor shall make a statement that there is nothing in the contract or organization's policies, handbooks, etc. that would restrict the physician's employment upon termination of the contract. The purpose of the NC Office of Rural Health's participation in this waiver program is to gain a physician for an underserved community.

10. Does the health care facility agree to notify the North Carolina Office of Rural Health (NCORH) in writing of the start date of employment?
 Yes No Already employed by facility

Documentation Required: No additional documentation is required to accompany this application. The health care facility shall notify NCORH of the employment start date of the NIW physician. This start date will be used to determine the due dates for the annual reports.

11. Does the health care facility agree to notify NCORH in the event of any change in the NIW physicians' employment status, employment contract or a change in the ownership of the health care facility for the duration of the NIW physician's obligation period? Yes No

Documentation Required: No additional documentation is required to accompany this application. Changes of the employment contract must be submitted to NCORH for review and approval prior to implementation (see Monitoring and Reporting Requirements). Any changes in employment status may jeopardize the visa status of the NIW physician.

12. Do the health care facility and NIW physician agree to provide, annually, reports to the NCORH for the duration of the NIW physician's period of obligation, from the start date of employment?
Yes No

Documentation Required: The annual report, Statement of Service form, must be completed and submitted to the NCORH within 30 days following the end of each 12-month period following the initial date of employment. If the health care facility and/or NIW physician do not submit their required reports, NCORH will find them out of compliance, and may result in consequences; such as the termination of this agreement, a noncompliance report to US Citizenship & Immigration Services (USCIS), and/or the ineligibility of the facility for future placements.

13. Additional documents to be submitted with this Application:

- A) Signed NCORH's National Interest Waiver Affidavit and Agreement.
- B) Narrative of health care facility's involvement with other community safety-net providers (county health department, community health center, etc.), **if private employer**.
- C) A copy of all current employment agreements.
- D) G-28(s) if attorney used.

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