# North Carolina Office of Rural Health
# National Interest Waiver Guidelines

*The physician must:*

1. Work full-time (40 hours per week) in a clinical practice located in a Health Professional Shortage area (as defined by the Untied 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).

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 Liquidation Damages Provision.

5. 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:


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

*For information:*
Phone (919) 527-6496
Fax (919) 733-8300
Email
clint.cresawn@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 referral to the State Attorney General's Office for collection of the National Interest Waiver Affidavit and Agreement Liquidation Damages Provision.

The physician and employer must submit annual reports (Attachment 1) to NCORH, which assure that the sponsoring employer and the physician, are complying with the requirements of the program. The first reports 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:

   Social Security Number:

2. Practice Site Location:

3. Home Address:

4. Practice Telephone Number (Area Code/Number):

5. Reporting Period: From

   To

6. Obligation Period: From

   To

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

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

9. Average number of hours worked per week in other practice settings:
   Home _____ Nursing Home _____ Other _____

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

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

12. 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 primary medical care in regions designated by the United States Public Health Service ("USPHS") 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 primary medical care services to patients, including the indigent, for a minimum of forty (40) hours per week within a USPHS 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 Immigration and Naturalization Service (INS) and shall continue for a minimum of five (5) years from latter of either the INS 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 Liquidated Damages Provision ("Liquidated Damages Provision"). The Liquidated Damages Provision is incorporated herein by reference. A copy of all current employment agreements shall be attached hereto. The attached Liquidated Damages Provision shall be activated by my termination of employment, initiated by my employer for cause or by me for any reason, but only if my termination occurs before fulfilling the minimum five (5) year service requirement. 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 INS 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 INS 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, the NCORH will notify the State Attorney General's Office and recommend collection proceedings be instituted against me. 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 AFFIDAVIT AND AGREEMENT**
**LIQUIDATION DAMAGES PROVISION**

Any breach or non-fulfillment of conditions set forth in the National Interest Waiver Affidavit and Agreement (the "Agreement") by me shall be considered to be a substantial and material breach of the Agreement by me. If there is such a breach or non-fulfillment of the Agreement, NCORH may, at its sole option and discretion, terminate the Agreement immediately and without notice to me. In addition, I agree that the NCORH will be substantially and materially damaged by my failure to remain at _____ (Name of Employer) for a minimum of five (5) years. I understand and agree that calculating the exact amount of damages to NCORH is difficult; therefore, I agree to pay to NCORH the amount of $250,000.00 for my failure to fulfill the minimum five-year contract term. In addition to liquidated damages, NCORH may recover from me any other consequential damages, and reasonable attorney's fees, due to my failure to provide services to _____ (Name of Employer) for a minimum of five years. Notwithstanding the foregoing, in the event of my approved transfer by NCORH to another licensed medical facility in a Health Professional Shortage area (as defined by the United States Public Health Service) within the State of North Carolina, such an approved transfer shall be considered the same as fulltime practice of medicine at _____(Name of Employer) for purpose of this Liquidated Damages Provision. Any a dispute arising out of the National Interest Waiver Affidavit Agreement and this Liquidated Damages Provisions, shall be brought in the Superior Court of the State of North Carolina located in Raleigh, North Carolina and in no other forum.

BY: _____
Printed Name: _____

Date: _____

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

_____
(Notary Public)

My Commission expires: _____

North Carolina Office of Rural Health
National Interest Waiver
APPLICATION

| NIW PHYSICIAN | HOME COUNTRY | DATE OF BIRTH | PRIMARY CARE SPECIALTY |
|---|---|---|---|
| | | | |

| ADDRESS | CITY | ZIP |
|---|---|---|
| | | |

| TELEPHONE # | FAX # | EMAIL |
|---|---|---|
| | | |

*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 # | FAX # |
|---|---|---|
| | | |

| ADDRESS | CITY | ZIP |
|---|---|---|
| | | |

*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)*_____

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 |
|---|---|---|---|
| Monday | AM: | PM: | |
| 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 |
|---|---|---|---|
| Monday | AM: | PM: | |
| Tuesday | | | |
| Wednesday | | | |
| Thursday | | | |
| Friday | | | |
| Saturday | | | |
| Sunday | | | |

7. Does the health care facility have an existing discounted/sliding fee schedule?
☐ Yes ☐ No

8. 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.

9. 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.

10. 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 primary medical care and; c) salary to be paid the NIW physician.

11. Does the health care facility agree to notify the North Carolina Office of Rural Health and Community Care (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.

12. 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 the department 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.

13. 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 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 notify the State Attorney General's Office for collection of the agreed-upon liquidated damages amount of $250,000.

14. Additional documents to be submitted with this application:

    A) NCORH's National Interest Waiver Affidavit and Agreement.
    B) Signed National Interest Waiver Affidavit and Agreement Liquidation Damages Provision.
    C) Narrative of health care facility's involvement with other community safety-net providers (county health department, community health center, etc.), ***if private employer***.

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*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 |