



Health Systems Quality Assurance, Office of Community Health Systems
Mental Health Provider Survey

I - PROVIDER INFORMATION

1. Last Name, Suffix (e.g. Sr., Jr.) _____	2. First Name _____	3. Middle Name _____	4. Birth Year _____	5. Gender <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Unanswered
6. Credentials:	<input type="checkbox"/> M.D. (Doctor of Medicine) <input type="checkbox"/> D.O. (Doctor of Osteopathic)			
7. Specialty:	<input type="checkbox"/> General Psychiatry <input type="checkbox"/> Child Psychiatry <input type="checkbox"/> Other: _____			
8. Provider Practice Name _____			9. Practice Phone Number _____	
10. Practice Street Address _____		11. City _____	12. Zip Code _____	13. County _____

Does provider have a **secondary practice**?

Secondary Practice Name, Address (Street, City, Zip Code) _____ County _____

14. Is the Provider a US citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No	14b. If Provider is not a US citizen, what is the current visa status?
		<input type="checkbox"/> J-1 Visa Waiver <input type="checkbox"/> Permanent US Resident (Green Card) <input type="checkbox"/> H-1B Visa Holder <input type="checkbox"/> Other Visa _____
15. Current Provider Status:	<input type="checkbox"/> Locum Tenens <input type="checkbox"/> Intern or Resident <input type="checkbox"/> Faculty <input type="checkbox"/> Restricted License <input type="checkbox"/> None listed <input type="checkbox"/> Other _____	
16. Does provider practice as?	<input type="checkbox"/> Hospitalist _____ hours per week <input type="checkbox"/> Neither <input type="checkbox"/> Staff Psychiatrist _____ hours per week <input type="checkbox"/> Unknown	
17. Does the Provider intend to leave within 6 months:	<input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> Yes: explain _____	
18. Does Provider have hospital admitting privileges?	<input type="checkbox"/> No <input type="checkbox"/> Not sure <input type="checkbox"/> Yes: list hospital(s) _____	

II - PRACTICE INFORMATION

	Primary Practice	Secondary Practice
19. Please list the best estimate of weekly hours for this provider: (Please list whole numbers)	Psychiatric Clinical Care _____ hours/week (General direct adult/child patient care) Sub-Specialty Care _____ hours/week (Teaching, forensics, research, please include hours as staff at: hospital or; juvenile or adult correctional facility) Non-Clinical Care _____ hours/week (Clinic administration; continuing education, lecturing, vacations, etc.)	Psychiatric Clinical Care _____ hours/week (General direct adult/child patient care) Sub-Specialty Care _____ hours/week (Teaching, forensics, research, please include hours as staff at: hospital or; juvenile or adult correctional facility) Non-Clinical Care _____ hours/week (Clinic administration; continuing education, lecturing, vacations, etc.)
20. In a typical week what is the average number of patients seen by this provider?	_____ average # of patients/week	_____ average # of patients/week
21. What additional language(s) besides English are spoken at this practice?	<input type="checkbox"/> None <input type="checkbox"/> Language(s) _____ _____	<input type="checkbox"/> None <input type="checkbox"/> Language(s) _____ _____

<p>22a. Are interpretative services provided?</p> <p>22b. How are services provided?</p>	<p><input type="checkbox"/> None <input type="checkbox"/> Services: _____</p> <p><input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides</p>	<p><input type="checkbox"/> None <input type="checkbox"/> Services: _____</p> <p><input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides</p>
<p>23. What percentage of this provider's current patients is: (Please list whole numbers.)</p>	<p>a. Transitory agricultural migrant farm worker and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Migrant _____ %</p> <p>b. Homeless and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless _____ %</p>	<p>a. Transitory agricultural migrant farm worker and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Migrant _____ %</p> <p>b. Homeless and/or their dependents? <input type="checkbox"/> None <input type="checkbox"/> Unknown <input type="checkbox"/> Homeless _____ %</p>
<p>III- PAYOR INFORMATION</p>		
<p>24. Private Insurance</p> <p>Insurance through work or self-purchased; include Basic Health, military.</p>	<p>Primary Practice</p> <p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>Secondary Practice</p> <p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>25. Medicaid</p> <p>Federal and state administered payment for low income; include Fee for Service and Healthy Options.</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>26. Medicare</p> <p>Federally administered payment for senior citizens and some disabled persons under age 65; include Fee for Service and Managed Care.</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>27. Self-Pay Patients</p> <p>No insurance; patient pays full fees.</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>28. Sliding Fee Scale (SFS)</p> <p>No insurance or subsidies; fees discounted according to income level; include Charity.</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>29. Is the SFS visibly posted and available to all patients?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p>
<p>30. Other: _____ (Please describe)</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>	<p>_____ % of all payee types Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown Restrictions: _____</p>
<p>Sum percentages should be 100%</p>	<p>_____ % Payee Type Total</p>	<p>_____ % Payee Type Total</p>
<p>ADDITIONAL INFORMATION</p>		
<p><i>Comments:</i></p> 		
<p><i>This survey was completed by:</i></p>		
<p>Name: _____ Title: _____</p>		
<p>Phone: _____ E-mail: _____</p>		
<p>Questions: Phi Ly (360) 236-2825; return to: DOH, OCHS, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 236-2830</p>		