

Thank you for participating in this Mental Health Provider Survey. Your information will help us understand the healthcare needs in your area. We will use the results to determine if your service area qualifies for designation as a Health Professional Shortage Area (HPSA). The HPSA designation will help eligible providers qualify for over 30 federal programs.

Information collected will also be used by the Department of Health and your local health department to study other mental healthcare access concerns. Results from any studies will be presented in aggregate form and will not identify individual providers. This guide will provide explanation to the questions.

We request that a survey be completed for each individual psychiatrist at the practice site. For questions regarding survey information requested please contact [Phi.Ly@doh.wa.gov](mailto:Phi.Ly@doh.wa.gov) or (360) 236-2825.

#### I - PROVIDER INFORMATION

1.-5.	Please provide the <b>complete, full name</b> of the provider, including the <b>birth year</b> and <b>gender</b> .
6.	Check the appropriate provider <b>credentials</b> : <ul style="list-style-type: none"> <li>▪ M.D. (Doctor of Medicine)</li> <li>▪ D.O. (Doctor of Osteopathic)</li> </ul>
7.	Indicate the specialty for this provider.
8.-13.	List the primary <b>practice site name</b> for this provider. Include the complete <b>street address, city, zip code, county</b> , as well as the site's <b>phone number</b> . Provide the <b>mailing address</b> if it is different than the physical street address. (8a.-13a.)
	If this provider has a <b>secondary practice site</b> include the name, street address, phone number and county. Additional information about the secondary practice should only be completed if known (Questions 18-30)
14.	a. Mark if the provider is a <b>US citizen</b> . If no, then answer 14b. b. For non-citizens identify what the provider's current visa status is.
15.	Mark the <b>program or status</b> that applies to the provider, otherwise mark "None Listed".
16.	Indicate if the provider practices as a " <b>Hospitalist</b> " or " <b>Staff Psychiatrist</b> " and how many hours per week worked in those roles. If this not applicable indicate "Neither".
17.	If the provider intends to <b>leave practice within the next six months</b> , please explain the reason(s).
18.	If the provider has hospital <b>admittance privileges at area hospitals</b> list the hospital names.

#### II - PRACTICE INFORMATION

19.	Please list in whole numbers the best <b>estimate of weekly hours</b> the provider spends on each of the following: <ul style="list-style-type: none"> <li>▪ <u>Psychiatric Clinic Care</u>: Includes general direct adult or child patient care.</li> <li>▪ <u>Sub-specialty Care</u>: Includes teaching, forensics, and research; please also include hours as staff at hospital or juvenile or adult correctional facility.</li> <li>▪ <u>Non-Clinical</u>: Clinic administration; continuing education, lecturing, hospital meetings, etc.</li> </ul>
20.	Provide a best estimate <b>average number of patients</b> seen in a typical week for primary psychiatric clinical care at this practice site. Also list for the secondary practice site if known.
21.	Please indicate whether an <b>alternative language</b> is spoken at the practice site(s). List all non-English languages spoken with patients.
22a. 22b.	Please indicate if <b>interpretative services</b> offered at the practice site(s) and how it these services are provided. This may include non-English translation, sign language, etc.

23.	<p>Identify what percentage of the provider's dental patients is:</p> <p>a) <b>Transitory agricultural migrant farm workers</b> are defined as no having a permanent local address in the same area as the Practice. Please include dependents in the average number.</p> <p>b) <b>Homeless persons</b> are defined as those living in unstable, nonpermanent locations, such as in shelters, transitional housing, in tents, in cars or on the streets. Please include dependents in the average number.</p>
<b>III - PAYER INFORMATION</b>	
24. – 30.	<p>For each of the payee type(s) provide the <b>best percentage estimate</b>. In determining the percentage estimate please consider how much of the identified payee type accounts for the business.</p> <p>Also mark whether or not the provider is <b>accepting new patients</b> and if there are restrictions. This information will be used to identify need in your area.</p> <ul style="list-style-type: none"> <li>▪ 24. <u>Private Insurance</u>: Dental insurance through work or self-purchased; include Basic Health, military.</li> <li>▪ 25. <u>Medicaid</u>: Federal and state administered payment for low income persons; include Fee for Service and Healthy Options.</li> <li>▪ 26. <u>Medicare</u>: Federally administered payment for senior citizens and some disabled persons under age 65; include Fee for Service and Managed Care.</li> <li>▪ 27. <u>Self Pay Patients</u>: No dental insurance; patient pays full fees.</li> <li>▪ 28. <u>Sliding Fee Schedule (SFS)</u>: No dental insurance or subsidies; fees discounted according to income level; charity.</li> <li>▪ 29. Identify whether or not the <u>SFS is visibly posted</u> and available to all patients.</li> <li>▪ 30. <u>Other</u>: please identify payee type not already listed.</li> </ul> <p>*The sum percentages of Question 24-30 should total 100% for each practice.</p> <p>*For purposes of this survey and HPSA the Payer descriptions are prescriptive and may not reflect the provider's actual distribution. Please provide estimates if necessary.</p>
<b>ADDITIONAL INFORMATION</b>	
	<p><b>Comments:</b> Share any questions or concerns you, the provider or staff, may have about access to primary care and information which will help us understand the needs in your area. Please feel free to attach additional documentation. These comments may be shared with your county health department.</p>
	<p>Please provide <b>contact information</b> should our office have any questions regarding information on this survey.</p>
<p>Please return completed surveys to: DOH, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 236-2830</p>	

Survey Questions  
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