



Primary Care Provider Survey

To complete this Survey online: <http://www.doh.wa.gov/hsqa/ocrh>

Section I - PROVIDER INFORMATION

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| | | | |
| 1. Last Name, Suffix (e.g. Sr., Jr.) _____ | | 2. First Name _____ | 3. Middle Name _____ |
| | | 4. Birth Year _____ | 5. Gender _____ |
| 6. Credentials: | <input type="checkbox"/> M.D. (Doctor of Medicine) <input type="checkbox"/> D.O. (Doctor of Osteopathy) <input type="checkbox"/> P.A. (Physician Assistant) <input type="checkbox"/> L.M. (Licensed Midwife) | | |
| | <input type="checkbox"/> A.R.N.P. (Advanced Registered Nurse Practitioner; not C.N.M.) <input type="checkbox"/> C.N.M. (Certified Nurse Midwife-A.R.N.P.) | | |
| 7. Primary Practice Name _____ | | 8. Practice Phone Number _____ | |
| 9. Practice Street Address _____ | | 10. City _____ | 11. Zip Code _____ |
| 12. County _____ | | | |
| Does this primary care provider have a secondary practice? _____ | | | |
| Secondary Practice Name , Address (Street, City, Zip Code) _____ | | County _____ | |
| 13. Primary Care Specialty: (mark all that apply) | <input type="checkbox"/> Family Practice <input type="checkbox"/> General Practice <input type="checkbox"/> General Internal Medicine <input type="checkbox"/> OB/Gyn | | |
| | <input type="checkbox"/> General Geriatrics <input type="checkbox"/> General Pediatrics <input type="checkbox"/> Other: _____ <small>Please specify</small> | | |
| 14. Does the provider: | a) Offer prenatal care? <input type="checkbox"/> No <input type="checkbox"/> Yes b) Attend births? <input type="checkbox"/> No <input type="checkbox"/> Yes - _____ # per year | | |
| 15a. Is the provider a US citizen? | <input type="checkbox"/> Yes | 15b. 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 _____ | |
| | <input type="checkbox"/> No | | |
| 16. Provider participating in: (mark all that apply) | <input type="checkbox"/> Locum Tenens | | <input type="checkbox"/> J-1 Visa Waiver Program |
| | <input type="checkbox"/> Intern or Resident | | <input type="checkbox"/> National Health Services Corps |
| | <input type="checkbox"/> Federal Employee (e.g. IHS, PHS) | | <input type="checkbox"/> Restricted License |
| | <input type="checkbox"/> State Loan Repayment /Program/Scholarship | | <input type="checkbox"/> Other _____ |
| 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 the provider have hospital admitting privileges: | <input type="checkbox"/> No <input type="checkbox"/> Yes – (list all hospitals) _____ | | |

| Section II - PRACTICE INFORMATION | Primary Practice | Secondary Practice <small>Please provide if known</small> |
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| 19. Please list the best estimate of weekly hours this provider spends on each of the following: | Primary Care _____ hrs/week <small>(Direct clinical primary care; hospital rounds for your primary care patients; exclude specialty care and non-clinical activities)</small> | Primary Care _____ hrs/week <small>(Direct clinical primary care; hospital rounds for your primary care patients; exclude specialty care and non-clinical activities)</small> |
| | Specialty Care _____ hrs/week <small>(High risk/surgical, allergy, cardiology, fertility, etc.; hospitalist hours; urgent and emergency medicine, etc.)</small> | Specialty Care _____ hrs/week <small>(High risk/surgical, allergy, cardiology, fertility, etc.; hospitalist hours; urgent and emergency medicine, etc.)</small> |
| | Non-Clinical Care _____ hrs/week <small>(Clinic administration; continuing education, lecturing, hospital meetings, etc.)</small> | Non-Clinical Care _____ hrs/week <small>(Clinic administration; continuing education, lecturing, hospital meetings, etc.)</small> |
| 20. In a typical week what is the average number of patients seen for primary care? | _____ avg. # of patients | _____ avg. # of patients |

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| 21. What additional languages besides English are spoken at this practice? | <input type="checkbox"/> None <input type="checkbox"/> Language _____ | <input type="checkbox"/> None <input type="checkbox"/> Language _____ |
| 22. How are interpretative services provided? 22b. Which interpretative services are provided? | <input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides Services: _____ | <input type="checkbox"/> None <input type="checkbox"/> Practice provides <input type="checkbox"/> Third party <input type="checkbox"/> Patient provides Services: _____ |
| 23a. What percentage of provider's patients are: Transitory agricultural migrant farm workers and/or their dependents? 23b. What percentage of provider's patients are: Homeless and/or their dependents? | <input type="checkbox"/> None <input type="checkbox"/> Migrant _____ % <input type="checkbox"/> None <input type="checkbox"/> Homeless _____ % | <input type="checkbox"/> None <input type="checkbox"/> Migrant _____ % <input type="checkbox"/> None <input type="checkbox"/> Homeless _____ % |
| Section III - PAYEE INFORMATION | Primary Practice | Secondary Practice |
| <i>Please provide the best estimate of each payee type.</i> | | <i>Please provide if known</i> |
| 24. Private Insurance <i>Insurance through work or self-purchased; include Basic Health, military.</i> | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ |
| 25. Medicaid <i>Federal and state administered payment for low income; include Fee for Service and Healthy Options.</i> | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ |
| 26. Medicare <i>Federally administered payment for senior citizens and some disabled persons under age 65; include Fee for Service and Managed Care.</i> | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ |
| 27. Self-Pay Patients <i>No insurance; patient pays full fees.</i> | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ |
| 28. Sliding Fee Scale <i>No insurance or subsidies; fees discounted according to income level; include Charity.</i> 28a. Is it visibly posted and available to all patients? | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes Restrictions: _____ <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 29. Labor and Industries (L&I) | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| 30. Other: _____ | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes | _____ % of all payee types Accepting New Patients: <input type="checkbox"/> No <input type="checkbox"/> Yes |
| The sum percentages should equal 100% for each site. | _____ % Payee Type Total | _____ % Payee Type Total |
| Comments: | | |
| This survey was completed by: | | |
| Name: _____ Title: _____ | | |
| Phone: _____ E-mail: _____ | | |
| Questions: Phi Ly (360) 236-2825 ; return to: DOH, OCHS, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 664-9273 | | |