



Primary Care Provider Survey

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

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. Credential:				
<input type="checkbox"/> M.D. (Doctor of Medicine) <input type="checkbox"/> D.O. (Doctor of Osteopathy) <input type="checkbox"/> P.A.-C. (Physician Assistant)		<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.) <input type="checkbox"/> L.M. (Licensed Midwife)		

A) _____ (_____) _____

7. Primary Practice Name _____ **8. Practice Phone Number** _____

9. Practice Street Address _____ **10. City** _____ **11. Zip Code** _____ **12. County** _____

B) _____

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

13. Primary Care Specialty: (Indicate the provider's <u>main</u> specialty)	<input type="checkbox"/> Family Practice <input type="checkbox"/> General Practice <input type="checkbox"/> General Internal Medicine <input type="checkbox"/> General OB/Gynecology	<input type="checkbox"/> General Geriatrics <input type="checkbox"/> General Pediatrics <input type="checkbox"/> Other: _____ (Please specify)
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14. Does the provider:

a) Offer prenatal care? No Yes Unknown

b) Attend births? No Yes - _____ # per year (estimate) Unknown

15a. Is the provider a US citizen?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	15b. If Provider is not a US citizen, what is the current visa status?
	<input type="checkbox"/> J-1 Visa Waiver <input type="checkbox"/> H-1B Visa Holder	<input type="checkbox"/> Permanent US Resident (Green Card) <input type="checkbox"/> Other Visa _____

16. Provider program or status: (Indicate which programs provider has participation.)	<input type="checkbox"/> Locum Tenens <input type="checkbox"/> Intern or Resident <input type="checkbox"/> Federal Employee (e.g. IHS, PHS) <input type="checkbox"/> State Loan Repayment Program/Scholarship <input type="checkbox"/> None	<input type="checkbox"/> Hospitalist <input type="checkbox"/> National Health Services Corps <input type="checkbox"/> Restricted License <input type="checkbox"/> Faculty <input type="checkbox"/> Other: _____
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17. Will provider leave within 6 months:

No Not sure Yes – explain: _____

18. Does the provider have hospital admitting privileges:

No Yes (list hospital): _____

II - PRACTICE INFORMATION

	Primary Practice	Secondary Practice
19. Please list the best estimate of weekly hours this provider spends on each of the following: (Please list whole numbers.)	Primary Care _____ hours/week (Direct clinical primary care; hospital rounds for your primary care patients; exclude specialty care and non-clinical activities) Specialty Care _____ hours/week (High risk/surgical, allergy, cardiology, fertility, etc.; hospitalist hours; urgent and emergency medicine, etc.) Non-Clinical _____ hours/week (Clinic administration; continuing education, lecturing, hospital meetings, etc.)	Primary Care _____ hours/week (Direct clinical primary care; hospital rounds for your primary care patients; exclude specialty care and non-clinical activities) Specialty Care _____ hours/week (High risk/surgical, allergy, cardiology, fertility, etc.; hospitalist hours; urgent and emergency medicine, etc.) Non-Clinical Care _____ hours/week (Clinic administration; continuing education, lecturing, hospital meetings, etc.)
20. In a typical week what is the average number of patients seen for primary care?	_____ # of primary care patients/week	_____ # of primary care 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 patient population is:</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 - PAYER INFORMATION</p>	<p>Primary Practice</p>	<p>Secondary Practice</p>
<p>24. Private Insurance</p> <p>Insurance through work or self-purchased; include Basic Health, military.</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>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</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>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</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>
<p>27. Self-Pay Patients</p> <p>No insurance; patient pays full fees or given cash discount at time of service.</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>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</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>
<p>28a. Is 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>29. Labor and Industries (L&I)</p> <p>Worker's compensation</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>
<p>30. Other:</p> <p>(Please describe) _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>	<p>_____ % of all payee types</p> <p>Accepting new patients? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Unknown</p> <p>Restrictions: _____</p>
<p>Sum percentages should be 100%</p>	<p>_____ % Payee Total for Primary Practice</p>	<p>_____ % Payee Total for Secondary Practice</p>
<p><i>Comments:</i></p>		
<p><i>Please enter contact information should our office have questions with the information provided.</i></p> <p>Name: _____ Title: _____</p> <p>Phone: _____ E-mail: _____</p> <p>Questions: Phi Ly (360) 236-2825; return to: DOH, P.O. Box 47853, Olympia, WA 98504-7853, or fax (360) 236-2830</p>		