### PRIMARY CARE PROVIDER SURVEY

1. Last Name, Suffix (e.g. Sr., Jr.)  
2. First Name  
3. Middle Name  
4. Birth Year

5. Credentials:  
   - [ ] M.D. (Doctor of Medicine)  
   - [ ] D.O. (Doctor of Osteopathy)  
   - [ ] P.A. (Physician’s Assistant)  
   - [ ] ARNP (Advanced Registered Nurse Practitioner)

6. Practice Name  
7. Phone Number

8. Practice Street Address  
9. City  
10. ZIP Code  
11. County

12. Practice Mailing Address (if different)  
13. City  
14. ZIP Code  
15. County

16. Primary Care Type: (HPSA guidelines include OB/GYN in primary care)  
   - [ ] Family Medicine  
   - [ ] General Medicine  
   - [ ] General Internal Medicine  
   - [ ] General OB/GYN  
   - [ ] General Geriatrics  
   - [ ] General Pediatrics  
   - Other/Specialty services: ____________________

17. Provider Program or Status: (Mark any that apply)  
   - [ ] National Health Service Corps  
   - [ ] State Loan Repayment/Scholarship  
   - [ ] J-1 Visa Holder  
   - [ ] H-1B Visa Holder  
   - [ ] Federal Employee (e.g. IHS,PHS)  
   - [ ] Resident or Intern  
   - [ ] Hospitalist: ______% of practice  
   - [ ] Faculty/Instructor/Research  
   - [ ] Locum Tenens  
   - [ ] Other: ____________________

18. Within the next six months does the provider plan to:  
   - [ ] Retire  
   - [ ] Move out of state  
   - [ ] Decrease hours  
   - [ ] Increase hours  
   - [ ] Move to different practice  
   - [ ] Unknown  
   - [ ] Other: ____________________

19. Does the provider have hospital admitting privileges?  
   - [ ] No  
   - [ ] Yes

20. Please estimate the number of weekly hours this provider spends on each of the following: (Please use whole numbers)  
   - Primary Care: ______ hours/week  
     (Direct clinical outpatient primary care, hospital rounds for your primary care patients, general OB/GYN and deliveries, volunteer work, etc.)  
   - Specialty Care: ______ hours/week  
     (Includes any type of specialty care, high-risk surgical procedures, hospitalist hours, urgent care, walk-ins, emergency medicine, etc.)  
   - Non-Clinical Duties: ______ hours/week  
     (Clinic administration, continuing education, teaching, research, meetings, etc.)

21. In a typical workweek, please estimate the number of patients seen by this provider for primary care services.  
   - Average number of patients: ______

22. Please estimate the number of days it takes to schedule a routine, non-urgent appointment.  
   - Established patients day(s)  
     - [ ] < 5 days  
     - [ ] 5 to 10 days  
     - [ ] 11 to 20 days  
     - [ ] 21 to 30 days  
     - [ ] > 30 days  
   - New patients day(s)  
     - [ ] < 5 days  
     - [ ] 5 to 10 days  
     - [ ] 11 to 20 days  
     - [ ] 21 to 30 days  
     - [ ] > 30 days
23. On average, if the patient arrives on time for their appointment how many minutes does it typically take to see the provider?

<table>
<thead>
<tr>
<th>Established patients minute(s)</th>
<th>New patients minute(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ &lt; 5 minutes</td>
<td>☐ &lt; 5 minutes</td>
</tr>
<tr>
<td>☐ 5 to 10 minutes</td>
<td>☐ 5 to 10 minutes</td>
</tr>
<tr>
<td>☐ 11 to 20 minutes</td>
<td>☐ 11 to 20 minutes</td>
</tr>
<tr>
<td>☐ 21 to 30 minutes</td>
<td>☐ 21 to 30 minutes</td>
</tr>
<tr>
<td>☐ &gt; 30 minutes</td>
<td>☐ &gt; 30 minutes</td>
</tr>
</tbody>
</table>

24. How are multilingual interpretative services provided? (check all that apply)

<table>
<thead>
<tr>
<th>Established patients</th>
<th>New patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic employee</td>
<td>☐</td>
</tr>
<tr>
<td>Telephone</td>
<td>☐</td>
</tr>
<tr>
<td>Community services</td>
<td>☐</td>
</tr>
<tr>
<td>Family or Friend</td>
<td>☐</td>
</tr>
<tr>
<td>Other: ____________</td>
<td>☐</td>
</tr>
</tbody>
</table>

25. Does provider serve the following patients? If yes, please estimate the percent of the patient population.

<table>
<thead>
<tr>
<th>Migrant farm workers:</th>
<th>Homeless people:</th>
<th>Apple Health (Medicaid):</th>
<th>Sliding Fee Scale:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Yes: _______ %</td>
<td>☐ Yes: _______ %</td>
<td>☐ Yes: _______ %</td>
<td>☐ Yes: _______ %</td>
</tr>
</tbody>
</table>

Is the Sliding Fee Scale posted and visible to all patients?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
<th>Unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

26. Is the provider accepting:

<table>
<thead>
<tr>
<th>Any new patients?</th>
<th>Any new Apple Health (Medicaid) patients?</th>
<th>Any new Sliding Fee Scale patients?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
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</tbody>
</table>

Survey completed by:

Name: _____________________________________________ Title: ___________________________________

Phone: ____________________________________________ Email: ___________________________________

Questions: Contact Randy Saylor at (360)236-2865 or Randall.Saylor@doh.wa.gov or Laura Olexa at (360)236-2811 or Laura.Olexa@doh.wa.gov

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