Healthcare Provider Assessment

Texas Primary Care Office

Please complete a separate assessment for all Primary Care Physicians, Psychiatrists, or Dentists at this practice site.
*If a provider practices as multiple locations, please fill out a separate survey **for each** additional location.*

A. Provider Information

Provider Name:	(First)	(Middle)	(Last)
TX Medical/ Dental License #:		**NPI #:**	**Discipline:** (choose one) ☐ Primary Care ☐ Psychiatry ☐ Dentistry

Specialty: (choose one)	**Primary Care:**		**Psychiatry:**		**Sub-specialty (if applicable):**
	☐ Family Practice	☐ Internal Medicine	☐ Psychiatrist	☐ Ped Nurse Spec	
	☐ OB/GYN	☐ Pediatrics	☐ Marriage/Family	☐ Clinical Social Work	
	Dentistry:	☐ General/Pediatric	☐ Clinical Psychology	☐ ____________	**% of Practice:** %

Practice Physical Address:		Does provider practice at multiple sites? ☐ Yes* ☐ No *If yes, complete an assessment for each site.*	
Practice City:	**State:**	**Zip Code:**	**County:**
Phone Number:	**Office email:**	**Practice Type:**	
Fax Number:	**Provider email:**	☐ Private ☐ Group ☐ Urgent Care ☐ Correctional ☐ State/County Mental Hospital ☐ Other:	

B. Provider Direct Care Hours per Week

1a. How many hours per week does physician provide Direct Outpatient care* (not to exceed 40 hours) at this site? _______ hours

This is direct care by the physician ONLY, including face-to-face time seeing patients in office, interpreting lab results, and consultations with other physicians. Do not include administrative hours, teaching/education/research hours, or inpatient hours (if also practicing at a hospital).* *#Inpatient Hours:*** ____________

1b. For Dentists: How many Auxiliaries does the provider have? ☐ Assistants ________________ ☐ Hygienists ____________

C. Patient Categories *(Please provide closest estimate if exact percentage unknown. If a specific category is not applicable to your practice, please enter "0" or "N/A.")*

2. What percentage of your patients have Medicaid coverage? ______________ %

3. What percentage of your patients use the Sliding Fee Scale (SFS)**? ______________ %

4. What percentage of patients are comprised of these special categories?

Homeless: _______ % Native American: __________ %

Migrant FW: _______ % Seasonal MFW: __________ %

*** A SFS is a formal discount policy based on income & family size or ability to pay (does not include bad debt write-offs). The SFS must be visibly posted and available to all patients.*

D. Patient Visits *(Please provide closest estimate if exact percentage unknown.)*

5. Is physician accepting new patients? ☐ Yes ☐ No

6. Average # of patients seen in a week? ____________ /wk

7. Average # of outpatient visits per year? ____________ /yr

	New Patient	*Established Patient*
8. Average wait time (days) for routine/non-urgent appointment?	____ days	_______ days
9. Average wait time (minutes) once patients arrive in the office?	____mins	____mins

E. Physician Status Information

10. Do any of the special categories below apply?

☐ National Health Services Corp
☐ Resident/Intern
☐ J-1 Visa Waiver Holder
☐ Federal Provider
☐ H-1B Visa Holder
☐ State Loan Repayment
☐ Locum Tenens
☐ Restricted License
☐ Hospitalist: __________ %
☐ Instructor: ___________ %

11. Within the next year, will the provider's status/location change? ☐ Yes ☐ No

☐ Retiring
☐ Moving to different practice
☐ Decreasing hours
☐ Moving out of state
☐ Increasing hours
☐ Other:

Comment(s):

Completed by: Title: Date:

Please return to Texas Primary Care Office via fax: 512-776-4232 or email: TexasPCO@dshs.texas.gov Questions: Please call the TPCO at (512) 776-7518.