TEXAS Health and Human Services | Texas Department of State Health Services

Healthcare Provider Assessment

Texas Primary Care Office

*Please complete a separate assessment for all **Primary Care Providers: Physicians, Psychiatrists, Dentists, and other core Healthcare providers** 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 ☐ Mental ☐ Dental	

Specialty: *(Please select field & indicate % of time of provider practice)*

Primary Care:		Psychiatry:		Dentistry:
☐ Family Practice	☐ Internal Medicine	☐ Psychiatrist	☐ Ped Nurse Spec	☐ General/Pediatric
☐ OB/GYN	☐ Pediatrics	☐ Marriage/Family	☐ Clinical Social Work	☐ Other
☐ Certified Nurse Midwife	☐ Licensed Midwife	☐ Clinical Psychology	☐ _____	**% of Practice:** _____%

Sub-specialty (if applicable): **% 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:**	☐ FQHC ☐ RHC
Fax Number:		**Provider email:**		☐ Private ☐ Group ☐ Urgent Care ☐ Correctional ☐ State/County ☐ Other: _____ Mental Hospital	

B. Provider Direct Care Hours per Week

1a. How many hours per week does provider practice Direct Outpatient care* (not to exceed 40 hours) at this site? _____hours

This is direct patient care by the MD, DO or DDS 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 (Hospital) 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 your 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/charity care policies). The SFS must be visibly posted and available to all patients and comply with NHSC policy.*

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.

8. Average wait time for routine/ non-urgent appointment? *New Patients* _____ Days *Established Patients* _____ Days

9. Average wait time(minutes) once patients arrive in the office _____ Mins _____ Mins

E. Provider Employment Status Information

10. Do any of the special categories below apply? ☐ Yes ☐ No

☐ National Health Services Corp ☐ Resident/Intern YR: _____

☐ 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: _____

Indicate Date (if known): _____

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.

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Submit By Email