Entity ID

Primary Care Clinician Survey

PC - A

Instructions: Please fill out all survey questions. Some information is pre-populated, based on information we have. Verify this information for accuracy. If correct, fill in the "Information Correct" bubble. If incorrect, correct the information.

Name: ○ Information correct

CO License: ○ Information correct

NPI number (if applicable): ○ Information correct

DEA Number(s) (if applicable): ○ Information correct

Medication Assisted Treatment Number (if applicable):

Does your practice offer formal language interpretation? Ⓨ Ⓝ

If yes, please describe below:

List all active board certifications (if applicable):

For the table below **verify**, **modify**, or **add** the name and physical address of each location where you currently practice. If you practice at more than two locations, **copy survey** and complete for all other locations.

	Main Practice ○ Information correct	Other Practice ○ Information correct
Name		
Physical Street Address		
City, Zip		
Phone		
Email		

In the table below, enter the value for each at your main location and other location identified above.

	Main Practice	Other Practice
Number of unique patients seen by you per **Year*:**		
Number of patient encounters seen by you per **Year*:**		
Hours of direct patient care delivered by you per **Week*:** Direct patient care is a visit between patient and clinician; rendering 1+ services		

**EXAMPLE: Number of unique patients/Number of encounters (10 patients seen once a month for a year: 10 unique patients and 120 encounters for a year) Please include each person only once as a patient. Each patient may have multiple encounters.*

What is the total number of hours you spend on professional duties not involving direct patient care per week? ______________

What is your employment status providing direct care to patients under your active medical license?

- ○ Actively working in a position that **requires** a medical license
- ○ Actively working in the medical field in a role that **does not** require a medical license
- ○ Actively working in a field that **does not** require a medical license
- ○ Not currently working
- ○ Retired
- ○ Other (explain)

If you **are not** currently providing direct care services, **stop here** and **return** (page 1 only) by fax 303-692-3562 or mail or email to cdphe_chsd@state.co.us, otherwise, continue to the next page. Thank you.

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For the table below, respond to the questions for each location identified on previous page.

	Main Practice	Other Practice
Fill in your best estimate for the percent of client/patient visits covered by each payment type in your practice for the past year: **Sliding fee scale (SFS): formal, posted discount policy based on income and family size*	________% Child Health Plan+ ________% HealthFirst Colorado (Medicaid) ________% Medicare ________% Pro bono/volunteer ________% Self-pay (not sliding fee scale*) ________% Sliding fee scale* ________% Commercial or private ________% N/A – VA or justice involved	________% Child Health Plan+ ________% HealthFirst Colorado (Medicaid) ________% Medicare ________% Pro bono/volunteer ________% Self-pay (not sliding fee scale*) ________% Sliding fee scale* ________% Commercial or private ________% N/A – VA or justice involved
Are you accepting new patients?	ⓨ ⓝ	ⓨ ⓝ
If yes, **select all** coverage options accepted for new patients: **Sliding fee scale: formal, posted discount policy based on income and family size*	◯ Child Health Plan+ ◯ HealthFirst Colorado (Medicaid) ◯ Medicare ◯ Pro bono/volunteer ◯ Self-pay (not sliding fee scale*) ◯ Sliding fee scale* ◯ Commercial or private ◯ N/A – VA or justice involved	◯ Child Health Plan+ ◯ HealthFirst Colorado (Medicaid) ◯ Medicare ◯ Pro bono/volunteer ◯ Self-pay (not sliding fee scale*) ◯ Sliding fee scale* ◯ Commercial or private ◯ N/A – VA or justice involved
In which type of setting do you practice? **Primary Care: providing comprehensive first contact and continuing care services for the prevention, diagnosis, and treatment of any undiagnosed sign, symptom or health concern not limited by problem origin or diagnosis*	☐ Outpatient primary care ☐ Outpatient urgent care ☐ Specialty care ☐ Inpatient ☐ Correctional facility ☐ Other	☐ Outpatient primary care ☐ Outpatient urgent care ☐ Specialty care ☐ Inpatient ☐ Correctional facility ☐ Other
How many **weeks** are you away from your practice (i.e., personal leave, professional education, other) in a calendar year?	_____________ weeks away	_____________ weeks away
What **percent** of your patient caseload being treated by you is provided via telemedicine? **Telemedicine: the remote diagnosis and treatment of a patient by means of telecommunications technology*	____________%	____________%

Fill in the **percent** of your patient caseload being treated by you in each of the following categories.

Main Practice	% Patients	Other Practice	% Patients
Pediatric Primary Care (children 17 and under)		Pediatric Primary Care (children 17 and under)	
General Primary Care (adults 18 -64)		General Primary Care (adults 18 -64)	
Geriatric Primary Care (adults 65+)		Geriatric Primary Care (adults 65+)	
Specialty Care (including emergency)		Specialty Care (including emergency)	
Pregnancy related services (prenatal and postnatal)		Pregnancy related services (prenatal and postnatal)	
MAT and/or SUD		MAT and/or SUD	

Name, title and phone number of person completing form　　　　　　　　Date completed

Additional Comments:

Please return **both pages** by fax 303-692-3562 or mail or email to cdphe_chsd@state.co.us. Thank you.