

ANNUAL CENSUS OF HEALTH CARE PROVIDERS 2010



Tennessee Department of Health
 Community Systems
 4th Floor – Cordell Hull Building
 425 5th Ave North
 Nashville, TN 37243
 Phone (615) 741-5226 Fax (615) 253-2100

Please provide the requested information about your current practice. **A separate questionnaire must be completed by each provider for each county and/or facility of practice.**

Please return the completed survey within **10 days of receipt**. Your timely response is greatly appreciated. Should you have questions or need additional information, please contact the Tennessee Department of Health, Community Health Systems at (615) 741-5226.

This annual census is being conducted statewide and will be used to determine state and federal health resource shortage areas for primary care providers. Information collected from this census allows designation of qualifying counties for participation in programs that provide financial incentives for primary care providers.

Provider ID <small>(For internal use)</small>	County of Practice
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License Number: _____

1) What is your Degree?

- | | |
|--|---|
| <input type="checkbox"/> Doctor of Osteopathy (D.O.) | <input type="checkbox"/> Nurse Practitioner/Advanced Practicing Nurse |
| <input type="checkbox"/> Medical Doctor (M.D.) | <input type="checkbox"/> Certified Nurse Midwife |
| <input type="checkbox"/> Physician Assistant | <input type="checkbox"/> Other: _____ |

2) Indicate your Specialty **and** Subspecialty along with the percentage of time spent in each practice.

	Specialty	Subspecialty	Percent of Practice		Specialty	Subspecialty	Percent of Practice
1. Family Practice	<input type="checkbox"/>	<input type="checkbox"/>	%	5. Obstetrics	<input type="checkbox"/>	<input type="checkbox"/>	%
2. General Practice	<input type="checkbox"/>	<input type="checkbox"/>	%	6. Gynecology	<input type="checkbox"/>	<input type="checkbox"/>	%
3. Pediatrics	<input type="checkbox"/>	<input type="checkbox"/>	%	7. OB/GYN	<input type="checkbox"/>	<input type="checkbox"/>	%
4. General Internal Medicine	<input type="checkbox"/>	<input type="checkbox"/>	%	8. Public Health	<input type="checkbox"/>	<input type="checkbox"/>	%
				Other :	<input type="checkbox"/>	<input type="checkbox"/>	%

3) Are you a: **U.S. Citizen** **Permanent Resident** or serve under a **H1B** or **J-1 Visa** waiver (Circle one)

4) Clinician Name: _____

Practice Name: _____

Practice Address: _____ Suite: _____

City: _____, TN ZIP: _____

Business Phone: (____) _____ Fax: (____) _____

Email: _____

5) Facility type: **Private Practice** **Safety Net** **FQHC** **Faith Based** **CHC** **RHC** **Other** (Circle all that apply)

If other, please explain: _____

6) How many hours per week do you provide direct patient care at this practice site? _____ **hr/wk**

Do not include on call, hospital or nursing home rounds, drug rehab centers, jail, emergency room shifts, or similar sites.

7a) Do you render care to your patients while they are hospitalized? That is, do you both admit your patients to the hospital and provide some of their care while they are hospitalized, rather than having a physician on the hospital staff follow? Yes, I follow my patients No, I do not follow my patients

b) If yes, indicate the average number of hours per week spent with hospitalized patients: _____

8) Do you work in a Medical Residency Program? Yes No Faculty or Resident

9) Do you serve under contract with either the Federal NHSC Scholarship or NHSC Loan Repayment Programs?

- Yes No

Questionnaire Continues on Back

10) Do you provide **Pediatric care** (general, routine) to 0-17 year olds? *Do not include pregnant teens or family planning.*
 Yes No If yes, percent of practice: _____

11) Do you provide:

Prenatal only: Yes No If yes, percent of practice : _____ %

Prenatal and delivery: Yes No If yes, percent of practice: _____ %

Number of deliveries you attended in the last 12 months (*estimate if necessary*): _____

Of these deliveries, what percent were TennCare? _____ %

12a) Do you currently have TennCare patients in your practice? Yes No (Skip to 13)

b) If yes, indicate the approximate percentage of your patients who use TennCare to pay for services.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

13) Do you accept **NEW TennCare** patients? Yes No

14) Are you currently accepting new patients into your practice (other than TennCare)?

Yes, I accept new patients No, my practice is closed or limited to current patients

15a) Do you offer a *published* sliding fee scale based on income or patient's ability to pay for services?

Yes No

b) Indicate the approximate percentage of your patients who pay for services based on a sliding fee scale.

0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100

16) **PHYSICIANS ONLY:** Do you supervise any physician assistants, advanced practice nurses, certified nurse midwives, etc. who have prescription-writing authority? Yes No

If yes, please fill in the chart below.

Name	Certification	Hours/Week	License No. (if known)
	<input type="checkbox"/> APN <input type="checkbox"/> PA <input type="checkbox"/> CNM		
	<input type="checkbox"/> APN <input type="checkbox"/> PA <input type="checkbox"/> CNM		
	<input type="checkbox"/> APN <input type="checkbox"/> PA <input type="checkbox"/> CNM		
	<input type="checkbox"/> APN <input type="checkbox"/> PA <input type="checkbox"/> CNM		

17) Do you practice at another site? *Do not include on call, hospital or nursing home rounds, drug rehab centers, jail, emergency room shifts, or similar sites.* Yes No

If yes, please complete and attach a separate survey for each practice site.

Please sign and date below:

Signature of person completing this census form

Title

Printed name of person completing this census form

Date

Office Use Only

Name: _____ Id No: _____

Spec		Sub		Hrs		Res		P&D		Pre		PD		TC		NTC		SFS	
%		%		Site		F/R		%		%		%		%				%	