

Primary Care Designation Worksheet
Primary Care Providers Questionnaire

(To be completed on all Primary Care Providers: Family Practice, General Practice, Internal Medicine, Pediatrician, and OB/GYN)

Name: _____

Address: _____

Telephone #: _____ Board Certified: _____ Yes _____ No

Specialty: _____ Percent of Practice: _____

Subspecialty: _____ Percent of Practice: _____

NHSC Scholar or Loan Repayment Participant: _____ Yes _____ No

J1 Visa Holder _____ Yes _____ No Resident or Intern _____ Yes _____ No

Federal Employee _____ Yes _____ No

Location of Practice: (city/county) _____ Zip Code: _____

How many hours per week are you engaged in **Outpatient Care** activities at this location? _____

Additional office location: (city/county) _____ Zip Code: _____

How many hours per week are you engaged in **Outpatient Care** activities at this location? _____

Do you have Hospital admitting privileges? _____ Yes _____ No

If applicable, how many hours per week are you engaged in **Inpatient Care** activities: _____ Location: _____

If you work less than 40 hours per week in Outpatient Care, a brief explanation should be provided (i.e. semi-retired, administrative duties, teaching, nursing home care, etc).

Do you routinely serve Medicaid patients at the office? _____ Yes _____ No

Do you routinely serve CMO patients at the office? _____ Yes _____ No

Do you offer a sliding fee scale based upon income or ability to pay? _____ Yes _____ No

If yes, what percentage of your practice is spent on sliding fee scale patients? _____

Please provide a copy of your sliding fee scale with this questionnaire.