DISTRICT OF COLUMBIA MENTAL HEALTH FULL-TIME EQUIVALENT (FTE) SURVEY

Identifiable information from this survey will be used exclusively for calculating population-to-provider ratios for the District's applications for geographic and population health professional shortage area (HPSA) designations for mental health. This information must be collected for each provider practicing in the District; complete and accurate responses will greatly assist the District in identifying areas with limited access to mental health care so that these areas can be made eligible to receive additional mental health resources. Please respond to all questions. Call 202-724-7668 for assistance.

First Name: _____ **Middle Initial**: _____

Last Name: _____ Suffix: _____

Date of Birth: _____/_____/_____ (MM / DD / YYYY) Provider's **DC License Number**:_____

Provider **Status**: ☐ Active ☐ Not in practice ☐ Moved out of the District

☐ Other (explain)_____

Is Provider a **Resident or Intern**?	☐ Yes	☐ No
Is Provider a **J1 Visa Holder**?	☐ Yes	☐ No
Is Provider a **Federal Employee**?	☐ Yes	☐ No
Is Provider a **National Health Service Corps (NHSC) Employee**?	☐ Yes	☐ No

Specialty: _____ Percent of Practice: _____

Subspecialty: _____ Percent of Practice: _____

Contact phone (with area code)**:** _____-_____-_____ **Email:** _____**@**_____.____

Practice Address 1 (Main): Street Address:_____
City: _____ State: _____ Zip:_____
Hours per week in DIRECT patient care activities at this site: _____

Practice Address 2 (Additional): Street Address:_____
City: _____ State: _____ Zip:_____
Hours per week in DIRECT patient care activities at this site: _____

Does Provider have **hospital privileges**? ☐ Yes ☐ No If, yes, are **hospital patient care hours** included in practice location hours? ☐ Yes ☐ No If yes, how many per week? _____

Out of a 40-hour week, approximately how many hours **are spent in administration, teaching, paperwork, semi-retirement, lunch breaks, etc.?** _____ Please circle the activities above or otherwise indicate which activities are included in this calculation: _____

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Does Provider serve the following patient groups? Percentage of patients seen in practice:

Homeless: ☐ Yes ☐ No _____
Medicaid: ☐ Yes ☐ No _____
Migrant Farmworkers: ☐ Yes ☐ No _____
Migrant/Seasonal Workers: ☐ Yes ☐ No _____
Native Americans: ☐ Yes ☐ No _____

Annual number of **Medicaid claims**: _____

Does Provider offer **sliding fee scale** based on income or ability to pay?
☐ Yes ☐ No Percentage of all patients that are sliding fee: _____

Does Provider practice offer **language interpretation** for patients? ☐ Yes ☐ No
What language? _____ Percentage of Patients: _____
What language? _____ Percentage of Patients: _____
What language? _____ Percentage of Patients: _____

Is Provider **accepting new patients**? ☐ Yes ☐ No

How long is the average **waiting time (days) for a routine, non-urgent appointment**?
New Patients (Days): _____ **Established** Patients (Days): _____

On average, how long do patients wait **once they have arrived in the office**?
New Patients (Minutes): _____ **Established** Patients (Minutes): _____

Does the Provider use an **electronic health record**? ☐ Yes ☐ No

Can DOH **share your response** regarding electronic health records and **your contact information** ONLY with the federally-funded Regional Extension Center (REC) that is assisting District providers with the transition to electronic health records? ☐ Yes ☐ No

RETURN BY FAX, EMAIL OR POST TO:
Primary Care Bureau
Community Health Administration
DC Department of Health
899 N. Capitol Street NE, 3rd Floor
Washington, DC 20002
Fax: 202-442-4947 Email: HPSA@DC.GOV

Save As Submit Form

THANK YOU FOR YOUR ASSISTANCE WITH THIS IMPORTANT EFFORT.