

# ANNUAL CENSUS OF HEALTH CARE PROVIDERS 2008



Tennessee Department of Health  
 Community Services  
 6<sup>th</sup> Floor – Cordell Hull Building  
 425 5<sup>th</sup> 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 **30 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 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 in the fields listed below. Information collected from this census allows designation of qualifying counties for participation in programs that provide financial incentives for primary care providers.

County of Practice \_\_\_\_\_

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** **H1B** or on a **J-1 Visa** (Circle one)

4) Clinician Name: \_\_\_\_\_

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_ Suite: \_\_\_\_\_

City: \_\_\_\_\_, TN ZIP: \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Email: \_\_\_\_\_

5) 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.**

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

7) 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? \_\_\_\_\_ %

**Questionnaire Continues on Back**

- 8) 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: \_\_\_\_\_ %
- 9) 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-up?  
 Yes, I follow my patients  No, I do not follow my Patients
- 10a) Do you currently have TennCare patients in your practice?  Yes  No (Skip to 12)  
 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**
- 11a) Do you accept **NEW TennCare** patients?  Yes  No  
 b) Indicate the approximate percentage of your practice you would devote to treating TennCare patients.  
**0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100**
- 12) 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
- 13a) 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**
- 14) **PHYSICIANS ONLY:** Do you supervise any physician assistants, nurse practitioners, certified nurse midwives, etc. who have prescription-writing authority?  Yes  No  
 (*DO NOT INCLUDE LPNs OR RNs WHO ARE NOT NURSE PRACTITIONERS*)  
 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		

- 15) Do you practice at another site? *Do not include hospital practice or nursing home as a site.*  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 <span style="float: right;">/ /</span>

Office Use Only																			
Name: _____									Id No: _____										
Spec		Sub		Hrs		Res		P&D		Pre		PD		TC		NTC		SFS	
%		%		Site		F/R		%		%		%		%		%		%	

