Nevada Division of Public and Behavioral Health – Primary Care Office
Healthcare Provider Assessment

Please complete a separate assessment for all Primary Care Physicians, Psychiatrists, or Dentists at this practice site.
*If a provider practices at multiple locations, please fill out a separate survey **for each** additional location.*
Email completed form to nvpco@health.nv.gov

A. Provider Information

Provider Name:	(First)	(Middle)	(Last)
NV Medical/ Dental License #:		**NPI #:**	**Discipline: (Choose one)** ☐ Primary Care ☐ Psychiatry ☐ Dentistry

Specialty: (Choose one)

Primary Care:		Psychiatry:		Sub-specialty (if applicable):
☐ Family Practice	☐ Internal Medicine	☐ Psychiatrist	☐ Ped Nurse Spec	
☐ OB/GYN	☐ Pediatrics	☐ Marriage/Family	☐ Clinical Social Work	
Dentistry:	☐ General/Pediatric	☐ Clinical Psychology	☐ _____	**% of Practice:** %

Practice Physical Address:				Does provider practice at multiple sites? ☐ Yes* ☒ No **If yes, complete an assessment for each site.*	
Practice City:		**State:**	NV	**Zip Code:**	**County:** Select County
Phone Number:		**Office email:**		**Practice Type:**	
Fax Number:		**Provider email:**		☐ Private ☐ Group ☐ Urgent Care ☐ Correctional ☐ State/County Mental Hospital ☐ Other: _____	

B. Provider Direct Care Hours per Week

1a. How many hours per week does physician provide Direct Outpatient care* (not to exceed 40 hours) at this site? _____ hours

This is direct care by the physician ONLY, including face-to-face time seeing patients in office, interpreting lab results, and consultations with other physicians. Do not include administrative hours, teaching/education/research hours, or inpatient hours (if also practicing at a hospital).* **#Inpatient Hours: _

1b. For Dentists: How many Auxiliaries does the provider have? ☐ Assistants _____ ☐ Hygienists _____

C. Patient Categories *(Please provide closest estimate if exact percentage unknown. If a specific category is not applicable to your practice, please enter "0" or "N/A.")*

2. What percentage of your patients have Medicaid coverage? _____ %
3. What % of your patients use the Sliding Fee Scale (SFS)**? _____ %

*** A SFS is a formal discount policy based on income & family size or ability to pay (does not include bad debt write-offs). The SFS must be visibly posted and available to all patients. *Estimate % as best as possible.*

4. What percentage of patients are comprised of these special categories?

Homeless: _____ % American Indian: _____ %
Migrant FW: _____ % Seasonal MFW: _____ %

D. Patient Visits *(Please provide closest estimate if exact number (or precentage) is unknown.)*

5. Is physician accepting new patients? ☐ Yes ☒ No

6. Average # of patients seen in a week? _____ /wk

7. Average # of outpatient visits per year? _____ /yr

☐ New patients not being accepted

	New Patient	Established Patient
8. Average wait time (days) for routine/non-urgent appointment?	_____ days	_____ days
9. Average wait time (minutes) once patients arrive in the office?	_____ mins	_____ mins

E. Physician Status Information

10. Do any of the special categories below apply?

☐ National Health Services Corp ☐ Resident/Intern
☐ J-1 Visa Waiver Holder ☐ Federal Provider
☐ H-1B Visa Holder ☐ State Loan Repayment
☐ Locum Tenens ☐ Restricted License
☐ Hospitalist: _____ % ☐ Instructor: _____ %

11. Within the next year, will the provider's status/location change?

☐ Yes ☐ No

☐ Retiring ☐ Moving to different practice
☐ Decreasing hours ☐ Moving out of state
☐ Increasing hours
☐ Other: _____

Completed by: **Title:** **Date:**

Please return to Nevada Primary Care Office (NV PCO) via email at nvpco@health.nv.gov or by clicking the "Submit by Email" button.
For questions, please call NV PCO at 775-684-2204. (vOct2021)

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