Indiana 2021 Physician License Renewal Information Fields

1. What is your employment status?

RADIO BUTTONS

a. Actively working in a position that requires a medical license
b. Actively working in a field other than medicine
c. Not currently working
d. Retired

2. What is your race? Mark one or more boxes.

MULTI CHECK BOX

a. American Indian or Alaska Native
b. Asian
c. Black or African American
d. Native Hawaiian/Pacific Islander
e. White
f. Some Other Race

3. Are you of Hispanic, Latina/o, or Spanish origin?

RADIO BUTTONS

a. Yes
b. No

4. Where did you complete your medical degree?

DROP-DOWN LIST

a. Indiana
b. Michigan
c. Illinois
d. Kentucky
e. Ohio
f. Another State (not listed)
g. Another Country (not U.S.)

5. Where did you complete your residency training?

DROP-DOWN LIST

a. Indiana
b. Michigan
c. Illinois
d. Kentucky
e. Ohio
f. Another State (not listed)
g. Another Country (not U.S.)

6. Which of the following best describes the area of practice in which you spend most of your professional time?

DROP-DOWN LIST

a. Adolescent Medicine
b. Anesthesiology
c. Allergy and Immunology
d. Cardiology
e. Child Psychiatry
f. Colon and Rectal Surgery
g. Critical Care Medicine
h. Dermatology

i. Endocrinology
j. Emergency Medicine
k. Family Medicine/General Practice
l. Gastroenterology
m. Geriatric Medicine
n. Gynecology Only
o. Hematology & Oncology
p. Infectious Diseases
q. Internal Medicine (General)
r. Nephrology
s. Neurological surgery
t. Neurology
u. Obstetrics and Gynecology
v. Occupational Medicine
w. Ophthalmology
x. Orthopedic Surgery
y. Other Surgical Specialties
z. Otolaryngology
aa. Pathology
bb. Pediatrics (General)
cc. Pediatrics Subspecialties
dd. Physical Medicine and Rehabilitation
ee. Plastic Surgery
ff. Preventive Medicine/Public Health
gg. Psychiatry
hh. Pulmonology
ii. Radiation Oncology
jj. Radiology
kk. Rheumatology
ll. Surgery (General)
mm. Thoracic Surgery
nn. Urology
oo. Vascular Surgery
pp. Other Specialties

7. Do you use telehealth to deliver services to patients located in Indiana (as defined in IC 25-1-9.5-6; "telehealth" means the delivery of health care services using interactive electronic communications and information technology, in compliance with the federal Health Insurance Portability and Accountability Act (HIPAA), including: (1) secure videoconferencing; (2) interactive audio-using store and forward technology; or (3) remote patient monitoring technology; between a provider in one (1) location and a patient in another location)?
RADIO BUTTONS
a. Yes
b. No

8. Please indicate which of the following services you routinely provide as a part of your practice: (Note: The purposes of this services list is to gather information on key health issues in Indiana) Please check all that apply.
CHECKBOXES
a. Addiction counseling
b. Dementia/Alzheimer's care
c. Hepatitis C Treatment/Management
d. High-risk Pregnancy services
e. HIV/AIDS Treatment/Management
f. Labor and delivery services

g. MAT (Medication Assisted Treatment) - Methadone
h. MAT (Medication Assisted Treatment) - Buprenorphine
i. MAT (Medication Assisted Treatment) - Naltrexone
j. Post-natal services
k. Pre-natal services
l. Screening for addiction (ex: SBIRT)
m. Screening for high-risk pregnancy
n. Treatment of OUD-affected Pregnant Women
o. None of the above

9. Please indicate the population groups to which you provide services:
   CHECKBOXES
   a. Newborns
   b. Children (ages 2-10)
   c. Adolescents (ages 11-19)
   d. Adults
   e. Geriatrics (ages 65+)
   f. Pregnant women
   g. Inmates
   h. Disabled individuals
   i. Individuals in recovery
   j. None of the above

10. What is the street address of your primary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

11. In what city is your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (64 CHARACTER LIMIT)

12. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
    DROP-DOWN LIST
    Please include all states' 2-letter postal abbreviation along with an option for N/A

13. What is the 5-digit ZIP code of your primary practice location? If this does not apply, please indicate "N/A"
    TEXT-BOX (5 CHARACTER LIMIT)

14. Which of the following categories best describes the practice setting at your primary practice location? If this does not apply, please select "not applicable."
    DROP-DOWN LIST
    a. Office/Clinic – Solo Practice
    b. Office/Clinic – Partnership
    c. Office/Clinic – Single Specialty Group
    d. Office/Clinic – Multi Specialty Group
    e. Hospital – Inpatient
    f. Hospital – Outpatient
    g. Hospital – Emergency Department
    h. Hospital – Ambulatory Care Center
    i. Federal Government Hospital
    j. Research Laboratory
    k. Medical School
    l. Nursing Home or Extended Care Facility

m. Home Health Setting
n. Hospice Care
o. Federal/State/Community Health Center(s)
p. Local Health Department
q. Telemedicine
r. Volunteer in a Free Clinic
s. Other
t. Not applicable

15. Estimate the average number of hours per week spent in direct patient care at your primary practice location. If this does not apply, please select "not applicable."
DROP-DOWN LIST
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

16. Estimate the percentage of Indiana Medicaid patients at your primary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not accept Indiana Medicaid
b. Indiana Medicaid accounts for >0% - 5% of my practice
c. Indiana Medicaid accounts for 6% - 10% of my practice
d. Indiana Medicaid accounts for 11% - 20% of my practice
e. Indiana Medicaid accounts for 21% - 30% of my practice
f. Indiana Medicaid accounts for 31% - 50% of my practice
g. Indiana Medicaid accounts for greater than 50% of my practice
h. Not applicable

17. Are you accepting new Indiana Medicaid patients at any or all of your practice locations?
RADIO BUTTONS
a. Yes
b. No

18. If you selected no on the previous question, but you are enrolled as an Indiana Medicaid provider, please describe barriers to participation.
TEXT BOX

19. Estimate the percentage of patients on a sliding fee scale at your primary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not offer a sliding fee scale
b. Sliding fee patients account for >0% - 5% of my practice
c. Sliding fee patients account for 6% - 10% of my practice
d. Sliding fee patients account for 11% - 20% of my practice

e. Sliding fee patients account for 21% - 30% of my practice
f. Sliding fee patients account for 31% - 50% of my practice
g. Sliding fee patients account for greater than 50% of my practice
h. Not applicable

20. What is the street address of your secondary practice location (for telehealth providers: where the patient is located)? If this does not apply, please indicate “N/A”.
TEXT-BOX (64 CHARACTER LIMIT)

21. In what city is your secondary practice location? If this does not apply, please indicate “N/A”.
TEXT-BOX (64 CHARACTER LIMIT)

22. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select “N/A”
DROP-DOWN LIST
Please include all states’ 2-letter postal abbreviation along with an option for N/A

23. What is the 5-digit ZIP code of your secondary practice location? If this does not apply, please indicate “N/A”.
TEXT-BOX (5 CHARACTER LIMIT)

24. Which of the following categories best describes the practice setting at your secondary practice location? If this does not apply, please select “not applicable.”
DROP-DOWN LIST
a. Office/Clinic – Solo Practice
b. Office/Clinic – Partnership
c. Office/Clinic – Single Specialty Group
d. Office/Clinic – Multi Specialty Group
e. Hospital – Inpatient
f. Hospital – Outpatient
g. Hospital – Emergency Department
h. Hospital – Ambulatory Care Center
i. Federal Government Hospital
j. Research Laboratory
k. Medical School
l. Nursing Home or Extended Care Facility
m. Home Health Setting
n. Hospice Care
o. Federal/State/Community Health Center(s)
p. Local Health Department
q. Telemedicine
r. Volunteer in a Free Clinic
s. Other
t. Not applicable

25. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. If this does not apply, please select “not applicable.”
DROP-DOWN LIST
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week

g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

26. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not accept Indiana Medicaid
b. Indiana Medicaid accounts for >0% - 5% of my practice
c. Indiana Medicaid accounts for 6% - 10% of my practice
d. Indiana Medicaid accounts for 11% - 20% of my practice
e. Indiana Medicaid accounts for 21% - 30% of my practice
f. Indiana Medicaid accounts for 31% - 50% of my practice
g. Indiana Medicaid accounts for greater than 50% of my practice
h. Not applicable

27. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not offer a sliding fee scale
b. Sliding fee patients account for >0% - 5% of my practice
c. Sliding fee patients account for 6% - 10% of my practice
d. Sliding fee patients account for 11% - 20% of my practice
e. Sliding fee patients account for 21% - 30% of my practice
f. Sliding fee patients account for 31% - 50% of my practice
g. Sliding fee patients account for greater than 50% of my practice
h. I am not currently practicing

28. What is the street address of your tertiary practice location (for telemedicine providers: where the patient is located)? If this does not apply, please indicate "N/A".
TEXT-BOX (64 CHARACTER LIMIT)

29. In what city is your tertiary practice location? If this does not apply, please indicate "N/A".
TEXT-BOX (64 CHARACTER LIMIT)

30. In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. If this does not apply, please select "N/A"
DROP-DOWN LIST
Please include all states' 2-letter postal abbreviation along with an option for N/A

31. What is the 5-digit ZIP code of your tertiary practice location? If this does not apply, please indicate "N/A".
TEXT-BOX (5 CHARACTER LIMIT)

32. Which of the following categories best describes the practice setting at your tertiary practice location? If this does not apply, please select "not applicable."
DROP-DOWN LIST
a. Office/Clinic – Solo Practice

b. Office/Clinic – Partnership
c. Office/Clinic – Single Specialty Group
d. Office/Clinic – Multi Specialty Group
e. Hospital – Inpatient
f. Hospital – Outpatient
g. Hospital – Emergency Department
h. Hospital – Ambulatory Care Center
i. Federal Government Hospital
j. Research Laboratory
k. Medical School
l. Nursing Home or Extended Care Facility
m. Home Health Setting
n. Hospice Care
o. Federal/State/Community Health Center(s)
p. Local Health Department
q. Telemedicine
r. Volunteer in a Free Clinic
s. Other
t. Not applicable

33. Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. If this does not apply, please select "not applicable."
DROP-DOWN LIST
a. 0 hours per week
b. 1 – 4 hours per week
c. 5 – 8 hours per week
d. 9 – 12 hours per week
e. 13 – 16 hours per week
f. 17 – 20 hours per week
g. 21 – 24 hours per week
h. 25 – 28 hours per week
i. 29 – 32 hours per week
j. 33 – 36 hours per week
k. 37 – 40 hours per week
l. 41 or more hours per week
m. Not applicable

34. Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not accept Indiana Medicaid
b. Indiana Medicaid accounts for >0% - 5% of my practice
c. Indiana Medicaid accounts for 6% - 10% of my practice
d. Indiana Medicaid accounts for 11% - 20% of my practice
e. Indiana Medicaid accounts for 21% - 30% of my practice
f. Indiana Medicaid accounts for 31% - 50% of my practice
g. Indiana Medicaid accounts for greater than 50% of my practice
h. Not applicable

35. Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. If this does not apply, please select "not applicable."
RADIO BUTTONS
a. I do not offer a sliding fee scale
b. Sliding fee patients account for >0% - 5% of my practice
c. Sliding fee patients account for 6% - 10% of my practice

d. Sliding fee patients account for 11% - 20% of my practice
e. Sliding fee patients account for 21% - 30% of my practice
f. Sliding fee patients account for 31% - 50% of my practice
g. Sliding fee patients account for greater than 50% of my practice
h. Not applicable

36. What are your employment plans for the next 2 years?
RADIO BUTTONS
a. Increase hours
b. Decrease hours
c. Seek non-clinical job
d. Retire
e. Continue as you are
f. Unknown