SERVICES FACILITY SURVEY

Provider Name & NPI # or Medicaid #:	**NP# :**	**MID#:**
Provider Type:		
City:		
Parish:		
Telephone Number and Email Address:		
Position and Individual Completing Survey:		
********Complete all questions in the survey, indicate yes, no, and the # of providers.*******		

Primary Care Services			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Family Medicine			
Internal Medicine			
Obstetrics			
Gynecology			
Pediatrics			
Geriatrics			
Lab Test			
X-Rays			
Other (Please Specify)			
Are any of these services contracted out?			

List the names & Medicaid provider numbers for each contracted service:

1
2
3

Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Physician			
Physician Assistant			
Nurse Practitioner			
Licensed Practical Nurse			
Clinical Nurse Specialist			
Registered Nurse			
Nurse Midwife			
Lab Technician			
X-Ray technician			
Other (Please Specify) Medical Assistants			

List the names & Medicaid provider numbers for each provider:

1
2
3
4
5
6
7
8
9
10

FQHC SERVICES FACILITY SURVEY

Dental Services			
	YES	NO	COMMENTS
Does your facility provide dental services?			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Diagnostic			
Preventive			
Restorative			
Endodontic			
Periodontal			
Prosthodontics			
Oral Surgery			
Other (Please Specify)			
Are any of these services contracted Out?			
List the names & Medicaid provider numbers for each provider:			
1			
2			
3			
4			
5			
Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Dentist			
Expanded Duty Dental Assistant			
Dental Assistant			
Dental Lab Technicians			
Other (Please Specify)			
COMMENTS:			

Mental Health Services			
	YES	NO	COMMENTS
Does your facility provide Mental Health Services?			
Please indicate which services are provided from the choices below:	**YES**	**NO**	**COMMENTS**
Evaluations			
Assessments			
Treatment			
Counseling			
Medication management			
Injections			
Other (Please Specify)			
Please indicate the availability of staff from the choices below:	**YES**	**NO**	**# of Providers**
Psychiatrist			
Clinical Psychologist			

Psychiatric Nurse Practitioner			
Licensed Clinical Social Worker			
Other (Please Specify)			

List the names & Medicaid provider numbers for each provider:

1
2
3
4
5

By signing below as the signature authority for this facility, I certify that the information above is complete, accurate, true and factual.

Signature and Title **Date**