Print Form

North Carolina Medical Society Foundation
Community Practitioner Program
COMMUNITY NEEDS QUESTIONNAIRE

To be completed by the applicant (use additional paper if necessary)

I. Personal Information

Name		Professional Status	
Type of Practice			
Name of Practice			
Month & Year Started Practicing		Month & Year Started Practicing Current Site	
Practice Address			
City/State/Zip		County	
Office Phone:		Home Phone:	
Home Address			
City/State/Zip		County	
Email Address		NC Medical Board License Number	

Have you ever been denied a license or have a license revoked or suspended by any professional licensing board? ☐ Yes ☐ No

Have you ever been warned, censured, disciplined, had admissions monitored, had privileges limited or denied by any licensed hospital, nursing home, clinic, or managed care organization? ☐ Yes ☐ No

Please include additional information on a separate page should explanation be required.

II. Practice Information

1. Practice's Management Structure and Principal Owner(s):

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2. Is this a federal, state, academic or hospital run practice? ☐ Yes ☐ No

3. List all providers and their professional status

4. Please provide historical evidence of past primary care shortages and the success or the lack thereof of previous attempts of recruiting and retaining providers.

III. Practice Setting's Willingness to Improve Access for the Underserved

1. Accept Medicaid? ☐ Yes ☐ No Percentage of practice:

   Number of Patients?

2. Accept Medicare? ☐ Yes ☐ No Percentage of practice:

   Number of Patients?

3. Indigent Care? ☐ Yes ☐ No Percentage of practice:

   Number of Patients?

4. Describe below the practice policy for indigent care.

IV. Technology and Quality

1. Does the practice have a certified Electronic Health Record or do you plan to acquire one? ☐ Yes ☐ No

2. If the practice has an EHR, are they working toward achieving Meaningful Use? ☐ Yes ☐ No

3. Does the practice have a strategic plan to obtain Patient Centered Medical Home status? ☐ Yes ☐ No

V. Evidence of Practice Viability

1. Describe the practice's night and weekend call schedule arrangements.

2. Is there a practice/business manager? ☐ Yes ☐ No

Name | Contact Number

Email Address

3. Name(s) of similar practitioners and/or practices in county.

4. Include any additional information you feel supports your request for financial assistance.

VI. Evidence That Practitioner and Family Will Fit Into the Community

1. Will practitioner live in the community? ☐ Yes ☐ No If no, please explain below.

2. Will practitioner's spouse accept and become a part of the community? ☐ Yes ☐ No

3. Will children attend local schools? ☐ Yes ☐ No

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4. Will practitioner become a part of the community? ☐ Yes ☐ No Please describe.

5. Other languages spoken?

VII. Availability of Other Funds for Assistance

1. What is practitioner's salary?

2. Do owners or partners have funds to assist applicant's educational loan repayment? ☐ Yes ☐ No

3. Does local hospital have funds to assist applicant's educational loan repayment? ☐ Yes ☐ No

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4. Are there income sources other than patient income? ☐ Yes ☐ No

VIII. Educational Loan Information

Loan amount: Undergraduate or living expense loans do not qualify.

Have you applied for state or federal educational grants? ☐ Yes ☐ No

Are you receiving state or federal education grants? ☐ Yes ☐ No

Please explain

Signature: Date:

Application must also include a copy of CV and current loan data statements supporting request.

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