1. What is your racial background? Please select all that apply.
   DROP-DOWN LIST OR RADIO BUTTONS
   White
   American Indian or Alaska Native
   Native Hawaiian/Pacific Islander
   Black or African American
   Asian
   Other

2. What is your ethnicity?
   DROP-DOWN LIST OR RADIO BUTTONS
   Hispanic or Latino
   Not Hispanic or Latino

3. Where did you complete your medical degree?
   DROP-DOWN LIST OR RADIO BUTTONS
   Indiana
   Michigan
   Illinois
   Kentucky
   Ohio
   Another State (not listed)
   Another County (not US)

4. Where did you complete your residency training?
   DROP-DOWN LIST OR RADIO BUTTONS
   Indiana
   Michigan
   Illinois
   Kentucky
   Ohio
   Another State (not listed)
   Another County (not US)

5. What is your employment status?
   DROP-DOWN LIST OR RADIO BUTTONS
   Actively working in a position that requires a medical license
   Actively working in a field other than medicine
Not currently working
Retired

6. Which of the following best describes the area of practice in which you spend most of your professional time? Please select only one response.

DROP-DOWN LIST
- Adolescent Medicine
- Anesthesiology
- Allergy and Immunology
- Cardiology
- Child Psychiatry
- Colon and Rectal Surgery
- Critical Care Medicine
- Dermatology
- Endocrinology
- Emergency Medicine
- Family Medicine/General Practice
- Gastroenterology
- Geriatric Medicine
- Gynecology Only
- Hematology & Oncology
- Infectious Diseases
- Internal Medicine (General)
- Nephrology
- Neurological surgery
- Neurology
- Obstetrics and Gynecology
- Occupational Medicine
- Ophthalmology
- Orthopedic Surgery
- Other Surgical Specialties
- Otolaryngology
- Pathology
- Pediatrics (General)
- Pediatrics Subspecialties
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine/Public Health
- Psychiatry
- Pulmonology
- Radiation Oncology
- Radiology
- Rheumatology
- Surgery (General)
- Thoracic Surgery
- Urology
- Vascular Surgery
- Other Specialties
7. What is the street address of your primary practice location?  
TEXT-BOX (64 CHARACTER LIMIT)

8. In what city is your primary practice location?  
TEXT-BOX (64 CHARACTER LIMIT)

9. In what state is your primary practice location? Please indicate state using 2-letter postal abbreviation.  
TEXT-BOX (2 CHARACTER LIMIT)

10. What is the 5-digit ZIP code of your primary practice location?  
TEXT-BOX (5 CHARACTER LIMIT)

11. Which of the following categories best describes the practice setting at your primary practice location?  
DROP-DOWN LIST OR RADIO BUTTONS  
Office/Clinic – Solo Practice  
Office/Clinic – Partnership  
Office/Clinic – Single Specialty Group  
Office/Clinic – Multi Specialty Group  
Hospital – Inpatient  
Hospital – Outpatient  
Hospital – Emergency Department  
Hospital – Ambulatory Care Center  
Federal Government Hospital  
Research Laboratory  
Medical School  
Nursing Home or Extended Care Facility  
Home Health Setting  
Hospice Care  
Federal/State/Community Health Center(s)  
Local Health Department  
Telemedicine  
Volunteer in a Free Clinic  
Other

12. Estimate the average number of hours per week spent in direct patient care at your primary practice location.  
DROP-DOWN LIST OR RADIO BUTTONS  
0 hours per week  
1 – 4 hours per week  
5 – 8 hours per week  
9 – 12 hours per week  
13 – 16 hours per week  
17 – 20 hours per week  
21 – 24 hours per week  
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

13. Estimate the percentage of Indiana Medicaid patients at your primary practice location.
   DROP-DOWN LIST OR RADIO BUTTONS
   I do not accept Indiana Medicaid
   Indiana Medicaid accounts for 0% - 5% of my practice
   Indiana Medicaid accounts for 6% - 10% of my practice
   Indiana Medicaid accounts for 11% - 20% of my practice
   Indiana Medicaid accounts for 21% - 30% of my practice
   Indiana Medicaid accounts for 31% - 50% of my practice
   Indiana Medicaid accounts for greater than 50% of my practice

14. Estimate the percentage of patients on a sliding fee scale at your primary practice location.
   DROP-DOWN LIST OR RADIO BUTTONS
   I do not offer a sliding fee scale
   Sliding fee patients account for 0% - 5% of my practice
   Sliding fee patients account for 6% - 10% of my practice
   Sliding fee patients account for 11% - 20% of my practice
   Sliding fee patients account for 21% - 30% of my practice
   Sliding fee patients account for 31% - 50% of my practice
   Sliding fee patients account for greater than 50% of my practice

15. What is the street address of your secondary practice location? Please skip this question if you do not have a secondary practice location.
   TEXT-BOX (64 CHARACTER LIMIT)

16. In what city is your secondary practice location? Please skip this question if you do not have a secondary practice location.
   TEXT-BOX (64 CHARACTER LIMIT)

17. In what state is your secondary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a secondary practice location.
   TEXT-BOX (2 CHARACTER LIMIT)

18. What is the 5-digit ZIP code of your secondary practice location? Please skip this question if you do not have a secondary practice location.
   TEXT-BOX (5 CHARACTER LIMIT)

19. Which of the following categories best describes the practice setting at your secondary practice location? Please skip this question if you do not have a secondary practice location.
   DROP-DOWN LIST OR RADIO BUTTONS
   Office/Clinic – Solo Practice
Office/Clinic – Partnership
Office/Clinic – Single Specialty Group
Office/Clinic – Multi Specialty Group
Hospital – Inpatient
Hospital – Outpatient
Hospital – Emergency Department
Hospital – Ambulatory Care Center
Federal Government Hospital
Research Laboratory
Medical School
Nursing Home or Extended Care Facility
Home Health Setting
Hospice Care
Federal/State/Community Health Center(s)
Local Health Department
Telemedicine
Volunteer in a Free Clinic
Other

20. Estimate the average number of hours per week spent in direct patient care at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
0 hours per week
1 – 4 hours per week
5 – 8 hours per week
9 – 12 hours per week
13 – 16 hours per week
17 – 20 hours per week
21 – 24 hours per week
25 – 28 hours per week
29 – 32 hours per week
33 – 36 hours per week
37 – 40 hours per week
41 or more hours per week

21. Estimate the percentage of Indiana Medicaid patients at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
I do not accept Indiana Medicaid
Indiana Medicaid accounts for 0% - 5% of my practice
Indiana Medicaid accounts for 6% - 10% of my practice
Indiana Medicaid accounts for 11% - 20% of my practice
Indiana Medicaid accounts for 21% - 30% of my practice
Indiana Medicaid accounts for 31% - 50% of my practice
Indiana Medicaid accounts for greater than 50% of my practice
22. Estimate the percentage of patients on a sliding fee scale at your secondary practice location. Please skip this question if you do not have a secondary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
- I do not offer a sliding fee scale
- Sliding fee patients account for 0% - 5% of my practice
- Sliding fee patients account for 6% - 10% of my practice
- Sliding fee patients account for 11% - 20% of my practice
- Sliding fee patients account for 21% - 30% of my practice
- Sliding fee patients account for 31% - 50% of my practice
- Sliding fee patients account for greater than 50% of my practice

23. What is the street address of your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

24. In what city is your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (64 CHARACTER LIMIT)

25. In what state is your tertiary practice location? Please indicate state using 2-letter postal abbreviation. Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (2 CHARACTER LIMIT)

26. What is the 5-digit ZIP code of your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

TEXT-BOX (5 CHARACTER LIMIT)

27. Which of the following categories best describes the practice setting at your tertiary practice location? Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
- Office/Clinic – Solo Practice
- Office/Clinic – Partnership
- Office/Clinic – Single Specialty Group
- Office/Clinic – Multi Specialty Group
- Hospital – Inpatient
- Hospital – Outpatient
- Hospital – Emergency Department
- Hospital – Ambulatory Care Center
- Federal Government Hospital
- Research Laboratory
- Medical School
- Nursing Home or Extended Care Facility
- Home Health Setting
- Hospice Care
- Federal/State/Community Health Center(s)
- Local Health Department
- Telemedicine
- Volunteer in a Free Clinic
28. Estimate the average number of hours per week spent in direct patient care at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
- 0 hours per week
- 1 – 4 hours per week
- 5 – 8 hours per week
- 9 – 12 hours per week
- 13 – 16 hours per week
- 17 – 20 hours per week
- 21 – 24 hours per week
- 25 – 28 hours per week
- 29 – 32 hours per week
- 33 – 36 hours per week
- 37 – 40 hours per week
- 41 or more hours per week

29. Estimate the percentage of Indiana Medicaid patients at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
- I do not accept Indiana Medicaid
- Indiana Medicaid accounts for 0% - 5% of my practice
- Indiana Medicaid accounts for 6% - 10% of my practice
- Indiana Medicaid accounts for 11% - 20% of my practice
- Indiana Medicaid accounts for 21% - 30% of my practice
- Indiana Medicaid accounts for 31% - 50% of my practice
- Indiana Medicaid accounts for greater than 50% of my practice

30. Estimate the percentage of patients on a sliding fee scale at your tertiary practice location. Please skip this question if you do not have a tertiary practice location.

DROP-DOWN LIST OR RADIO BUTTONS
- I do not offer a sliding fee scale
- Sliding fee patients account for 0% - 5% of my practice
- Sliding fee patients account for 6% - 10% of my practice
- Sliding fee patients account for 11% - 20% of my practice
- Sliding fee patients account for 21% - 30% of my practice
- Sliding fee patients account for 31% - 50% of my practice
- Sliding fee patients account for greater than 50% of my practice