SPECIAL NEEDS PROVIDER SURVEY FORM

(*Please complete all blank fields*)

Name: ____________________ **Specialty:** ____________________
Address: ____________________ **City, State Zip:** ____________________
E-Mail: ____________________ **Phone:** ____________________

1. **Please indicate *"Yes"* or *"NO"* with regard to which category of patients you currently treat in your practice:**

Aged	☐ Yes	☐ No
Disabled (including Blind)	☐ Yes	☐ No
Division of Developmental Disabilities (DDD)	☐ Yes	☐ No
HIV+/AIDS:	☐ Yes	☐ No
Other ____________________		

   a. **If you answered "Yes" to any of the above, please indicate your qualifications, including formal training and/or experience, to treat adults/children with special needs:**

2. **Are you willing to serve as a PCP and/or Specialist to members with special needs?** *(Check all that apply)*

	Ages 0-21	21-65	65 & older
☐ I am a Primary Care Provider willing to serve as a PCP to members with Special Needs*	☐	☐	☐
☐ I am a Specialist willing to serve as a PCP to members with Special Needs*	☐	☐	☐
☐ I am a Specialist willing to serve as a Specialist to members with Special Needs*	☐	☐	☐
☐ I am NOT willing to serve as a PCP/Specialist to members with Special Needs	☐	☐	☐

**Medical Management may contact you to assist in care of our Special Needs members*

3. **If you are willing to provide services to Aetna Better Health New Jersey Special Needs members, please check the category of members you are willing to see:** *(check all that apply)*

☐ Aged, Blind and Disabled (ABD)
☐ HIV+/AIDS
☐ Developmental Disabilities (DDD)
☐ I do not wish to be listed as a Special Needs Provider

4. **Appointment Availability** *(Check all that apply)*

Appointment Instructions: ☐ Appointment Only ☐ Appointment & Walk In ☐ Walk in Only
After hours Coverage: ☐ Answering Service ☐ Answering Machine ☐ Other ____________

5. **Does the office meet ADA Accessibility requirements?*** ☐ **Yes** ☐ **No**

Does the site offer handicapped access for the following? ☐ **Yes** ☐ **No**
Building? ☐ Yes ☐ No
Parking? ☐ Yes ☐ No
Restroom? ☐ Yes ☐ No

Does the site offer other services for the disabled? ☐ **Yes** ☐ **No**
Text Telephony (TTY) ☐ Yes ☐ No
American Sign Language ☐ Yes ☐ No
Mental/Physical Impairment Services ☐ Yes ☐ No

Accessible by public transportation? ☐ **Yes** ☐ **No**
Bus ☐ Yes ☐ No
Subway ☐ Yes ☐ No
Regional Train ☐ Yes ☐ No

Provider Printed Name: ____________________
Provider Signature or Designee: ____________________
Date: ____________________

Please complete and return to your Provider Liaison or to NJ_FIDESNP_Providers@aetna.com