

**Attachment A - B3**

**Augmentation screener questionnaire**

U.S. Department of Health and Human Services  
Substance Abuse and Mental Health Services Administration

FORM APPROVED:  
OMB No: 0930-XXXX  
Exp. date: MM/DD/YY

## 2006 N-SSATS AUGMENTATION SCREENER

Public burden for this collection of information is estimated to average 5 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB number for this project is 0930-XXXX.

MPR ID: | | | | | | | | | |

DATE: | | | | / | | | | 2005

MONTH DAY

FINAL STATUS: | | | |

INT ID#: | | | | | | | | | |

|                                      |                                   |
|--------------------------------------|-----------------------------------|
| 01 = COMPLETE                        | 08 = INELIGIBLE                   |
| 04 = PHYSICALLY CLOSED               | 24 = DUPLICATE FACILITY           |
| 05 = CAN'T LOCATE                    | 34 = MERGED FACILITY              |
| 06 = NO PARTICIPATION (EFFORT ENDED) | 44 = NO SUBSTANCE ABUSE TREATMENT |
| 07 = REFUSED                         | 54 = SATELLITE FACILITY           |

### IF NO ANSWER:

BUSY → **CALLBACK IN 10 MINUTES**

ANSWERING MACHINE (Facility name verified) →  **CALLBACK IN 1 HOUR**

ANSWERING MACHINE (Facility name NOT verified) →  **CALLBACK IN 1 HOUR**

NON-WORKING/FAX/FUNNY NUMBER → **CHECK THIS BOX  AND PLACE IN LOCATING BASKET**

**A1. Hello, this is [INTERVIEWER] calling on behalf of SAMHSA, the federal government's Substance Abuse and Mental Health Services Administration. SAMHSA is currently updating it's listing of facilities that provide substance abuse services. I would like to verify some address information with you.**

**IF SUBSTANCE ABUSE SERVICES CLEARLY NOT PROVIDED, CHECK THIS BOX  SKIP TO "END" (PAGE 3)**

1  WRONG NUMBER → **PLACE IN LOCATING BASKET**

2  APPROPRIATE RESPONDENT; CONTINUE → **SKIP TO B1 (PAGE 2)**

3  APPROPRIATE RESPONDENT; NEEDS CALLBACK →

**RECORD BEST TIME TO CALL BACK ON CONTACT SHEET (INCLUDE DAY, DATE AND TIME) AND READ:**

4  NOT APPROPRIATE RESPONDENT

**Thank you very much. I'll call back at that time.**

**A2. With whom should I speak? RECORD NAME OF CONTACT PERSON BELOW**

\_\_\_\_\_

**A3. May I speak with [NAME OF CONTACT PERSON]?**

1  AVAILABLE: WHEN RESPONDENT COMES TO PHONE, READ INTRO (A1) → **GO TO B1 (PAGE 2)**

2  NOT AVAILABLE → **RECORD BEST TIME TO CALL BACK ON CONTACT SHEET (INCLUDE DAY, DATE AND TIME) AND READ:**

**Thank you very much. I'll call back at that time.**

B1. First, I'd like to confirm that this is [FACILITY NAME], located at [LOCATION ADDRESS]. Is that correct?

**IF SUBSTANCE ABUSE SERVICES CLEARLY NOT PROVIDED, CHECK THIS BOX  SKIP TO "END" (PAGE 3)**

1  YES, NAME AND ADDRESS CORRECT → **SKIP TO B3**

0  NO, NAME AND/OR ADDRESS INCORRECT

B2. RECORD CORRECT INFORMATION BELOW:

NAME: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

B2a. INTERVIEWER: DID THE FACILITY NAME CHANGE?

1  YES

0  NO → **SKIP TO B3**

B2b. Was this facility ever called [FACILITY NAME]?

1  YES → **SKIP TO B3**

0  NO

B2c. Does this facility provide substance abuse treatment services?

1  YES

0  NO → **GO TO END**

B2d. INTERVIEWER: COMPLETE "NEW FACILITY SHEET" WHILE RESPONDENT IS ON THE PHONE. THEN, SKIP TO END AND PLACE CONTACT SHEET IN LOCATING BASKET AND "NEW FACILITY SHEET" IN RECEIPT CONTROL BASKET.

B3. Which of the following substance abuse services are offered by this facility, that is, the facility located at [LOCATION ADDRESS]?

PROBE IF NECESSARY: Please report for only this location.

MARK "YES" OR "NO" FOR EACH

|   | YES                        | NO                         |
|---|----------------------------|----------------------------|
| 1. Intake, assessment, or referral .....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 2. Detoxification .....   | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 3. Substance abuse treatment, that is services that focus on initiating and maintaining an individual's recovery from substance abuse and on averting relapse ..... | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 4. Halfway House Services.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |
| 5. Any other substance abuse services.....  | 1 <input type="checkbox"/> | 0 <input type="checkbox"/> |

**B3a. INTERVIEWER: DID THE RESPONDENT ANSWER "YES" TO DETOXIFICATION SERVICES, SUBSTANCE ABUSE TREATMENT, OR HALFWAY HOUSE IN B3 ABOVE (CATEGORIES 2, 3, or 4)?**

1  YES

0  NO → *SKIP TO END (FINAL STATUS CODE "44")*

**B4. Is [LOCATION ADDRESS] also the mailing address for this facility?**

1  YES → *SKIP TO B5*

0  NO

**B4a. What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?**

NAME: \_\_\_\_\_

STREET: \_\_\_\_\_

CITY/TOWN: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**B5. Does [FACILITY NAME] have a FAX number?**

1  YES →

**B5a. What is that FAX number? (\_\_\_\_\_) - \_\_\_\_\_ - \_\_\_\_\_**

0  NO

**B6. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Finally, who is the facility director for [FACILITY]? (RECORD BELOW)**

\_\_\_\_\_

**END: That's all the questions I have. Thank you very much for your time.**

**INTERVIEWER: FINAL STATUS AND PLACE IN COMPLETED BASKET.**

**NOTES:**