US Department of Health and Human Services

FORM NOT YET APPROVED
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APPROVAL EXPIRES: XX/XX/XXXX
See OMB burden statement on last page
Version 12/19/07

2008 National Survey of Mental Health Treatment Facilities

Substance Abuse and Mental Health Services Administration

PLEASE REVIEW THE INFORMATION PRINTED BELOW IN THE LEFT COLUMN.
PLEASE MAKE ANY CORRECTIONS USING THE RIGHT COLUMN BELOW.

FACILITY INFORMATION BOX

Current Information	Corrections
Facility Name (Line 1)	Facility Name (Line 1)
Facility Name (Line 2)	Facility Name (Line 2)
Street Address	Street Address
Mailing Address (if different)	Mailing Address (if different)
City / State / Zip Code / ZipFour	City / State / Zip Code / ZipFour
Phone Number / Extension	Phone Number / Extension
Fax Number	Fax Number
Facility Director	Facility Director

Current Web Site Address -- If the web address in the box below is correct, please check here: ☐

Corrected Web Site Address -- If the box above is blank or the web address is incorrect, enter the correct address below.

A. Is this the Main Administrative Facility? Yes ☐ **No** ☐

B. Are mental health services provided at this facility? Yes ☐ (Go to the next page and continue with the questionnaire)
No ☐ (Go to Question C)

C. Which of the following statements best describes this facility?

CHECK ONE ONLY

☐ It is an administrative facility only
☐ It provides substance abuse services
☐ It provides developmental disability services
☐ It performs some other service. Please specify:

CMHS FACILITY ID

Please complete the contact information in Section E (*page 12*) and return the questionnaire.

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PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE

INSTRUCTIONS

- Most of the questions in this questionnaire ask about this facility. By this facility we mean the specific treatment facility whose name and location are printed in the Facility Information Box on the front cover. If you have any questions about how the phrase this facility applies to your facility, please call the survey helpline at 1-800-722-6194.

  [**NOTE**: If you have corrected the address, please consider the facility at the corrected address.]

- Answer ONLY for the specific facility whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.

- Return the completed questionnaire in the envelope provided. Please keep a copy for your records.

- If you have any further questions or need additional blank forms, contact the survey helpline at:

1-800-722-6194
mhsurvey@s-3.com

Or write to:
Social & Scientific Systems, Inc.
PO Box 8548
Silver Spring, MD 20907-9907

Would You Rather Complete the Questionnaire Online?

You can choose to respond to this questionnaire using the Internet at http://mhsurvey.s-3.com/. See the pink information sheet enclosed in your questionnaire packet for your unique user ID and password. If this information has been misplaced, please contact the survey helpline at 1-800-722-6194.

IMPORTANT INFORMATION

- Information from asterisked (*) questions will be published in SAMHSA's online *Mental Health Services Locator* and will be available online at **http://mentalhealth.samhsa.gov/databases/**.

- Note that complete and accurate name and address information is needed for SAMHSA's online *Mental Health Services Locator* so it can correctly map the facility's location.

- Only facilities designated as eligible by SAMHSA will be listed in SAMHSA's online *Mental Health Services Locator*. The orange information sheet included in your packet describes the criteria used to determine eligibility. If you have any further concerns or questions regarding eligibilty, please contact the survey helpline at 1-800-722-6194.

CMHS FACILITY ID

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Questions? Call 1-800-722-6194

SECTION A: SERVICE CHARACTERISTICS

Section A asks about this facility's client/patients and services. Remember: This questionnaire asks about this facility *only*, the facility at the location listed in the Facility Information Box on the front cover.

1. In which of following settings are mental health services provided at this facility?

CHECK ALL SETTINGS THAT APPLY

- ☐ 24-hour hospital inpatient care
- ☐ 24-hour residential care
- ☐ Less than 24-hour outpatient/partial care

***2. Are substance abuse services also provided at this facility (the facility listed in the Facility Information Box on the front cover of the questionnaire)?**

- ☐ **Yes → CONTINUE WITH QUESTION 2a**
- ☐ **No → SKIP TO QUESTION 3**

***2a. In which of the following settings are substance abuse services provided at this facility?**

(CHECK ALL SETTINGS THAT APPLY)

- ☐ 24-hour hospital inpatient care
- ☐ 24-hour residential care
- ☐ Less than 24-hour outpatient/partial care

***3. What is the primary service focus at this facility?**

CHECK ONE ONLY

- ☐ Mental health services
- ☐ Substance abuse services
- ☐ Mix of mental health and substance abuse services *(neither is primary)*
- ☐ General health care *(neither mental health nor substance abuse services is primary)*
- ☐ Other service focus; please specify:

CMHS FACILITY ID

ANSWER ALL REMAINING QUESTIONS FOR MENTAL HEALTH SERVICES ONLY. (EXCLUDE ALL NON-MENTAL HEALTH SERVICES FROM YOUR RESPONSES.)

***4. What telephone number(s) should a potential client/patient call to schedule a mental health intake appointment at this facility?**

INTAKE TELEPHONE NUMBER(S)

1. ( ) - - Extension
2. ( ) - - Extension

4a. What are the hours of operation for the intake telephone number(s)?

From ____ AM__ PM__ To ____ AM__ PM__

Days of the Week: ____

☐ **This facility does not accept telephone calls for mental health intake appointments.**

***5. Does this facility operate a 24/7 hotline that responds to persons experiencing acute mental health problems?**

- *A hotline is a telephone service, available and staffed 24 hours a day, 7 days a week, that provides information, referral, and immediate counseling to the client/patient in a crisis situation.*
- ***DO NOT** consider 911, or the local police number, a hotline for the purpose of this survey.*

- ☐ **Yes → CONTINUE WITH QUESTION 5a**
- ☐ **No → SKIP TO QUESTION 6**

***5a. Enter the hotline telephone number(s) below.**

HOTLINE TELEPHONE NUMBER(S):

( ) - - Extension

( ) - - Extension

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***6. Which of the following mental health services are provided <u>at this facility</u>?** *For definitions of mental health services, please see the blue information sheet.*

CHECK ALL THAT APPLY

- **a.** ☐ Intake services
- **b.** ☐ Diagnostic evaluation
- **c.** ☐ Information and referral services
- **d.** ☐ Psychiatric emergency walk-in services
- **e.** ☐ Suicide prevention services
- **f.** ☐ Case management
- **g.** ☐ Psychosocial rehabilitation services
- **h.** ☐ Vocational rehabilitation services
- **i.** ☐ Legal advocacy
- **j.** ☐ Education services
- **k.** ☐ Housing services
- **l.** ☐ Consumer-run services
- **m.** ☐ Chronic disease/illness management
- **n.** ☐ Other; please specify:

***7. Which of the following mental health treatment approaches are provided <u>at this facility</u>?** *For definitions of mental health treatment approaches, please see the purple information sheet.*

CHECK ALL THAT APPLY

- **a.** ☐ Interpersonal psychotherapy
- **b.** ☐ Group therapy
- **c.** ☐ Couples counseling/family therapy
- **d.** ☐ Behavior modification
- **e.** ☐ Cognitive/Behavioral therapy
- **f.** ☐ Activity therapy
- **g.** ☐ Electroconvulsive therapy
- **h.** ☐ Psychotropic medication therapy
- **i.** ☐ Other; please specify:

8. Many people in recovery benefit from a number of supportive practices. Which of the following are provided by this facility? *For definitions of the supportive practices listed, please see the green information sheet.*

CHECK ALL THAT APPLY

ADULTS

- **a.** ☐ Supported housing
- **b.** ☐ Supported employment
- **c.** ☐ Assertive community treatment
- **d.** ☐ Family psychoeducation
- **e.** ☐ Integrated dual disorders treatment
- **f.** ☐ Illness management and recovery (IMR)

CHILDREN/ADOLESCENTS

- **g.** ☐ Therapeutic foster care
- **h.** ☐ Multisystemic therapy
- **i.** ☐ Functional family therapy

9. Does an acute care crisis intervention treatment team operate from this facility?

- ☐ Yes, within facility only
- ☐ Yes, off site only
- ☐ Yes, within facility and off site
- ☐ No

***10. Please identify the following functions at your facility that are accomplished <u>using computerized systems:</u>**

- **a.** ☐ Computerized results reporting (e.g., laboratory results, psychological testing)
- **b.** ☐ Computerized Physician Order Entry (CPOE) or outpatient prescriptions/directions
- **c.** ☐ Sending to and receiving clinical data from other providers
- **d.** ☐ Creating and transmitting referrals to other providers or services (e.g., employment placement, housing assistance, vocational training)
- **e.** ☐ Treatment plan creation and maintenance
- **f.** ☐ Problem list creation and maintenance
- **g.** ☐ Medication interaction checking
- **h.** ☐ Billing/claims preparation and submission
- **i.** ☐ Patient scheduling
- **j.** ☐ Process note-taking
- **k.** ☐ Other; please specify:

CMHS FACILITY ID

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***11. Indicate which age/gender categories of client/patients are accepted for treatment at this facility?**

CHECK YES OR NO FOR EACH CATEGORY

	YES	NO
a. Children/adolescents (17 or younger)	☐	☐
b. Adult women (18-64)	☐	☐
c. Adult men (18-64)	☐	☐
d. Seniors (65 or Older)	☐	☐

***12. Indicate whether the specially designed service programs listed below are provided at this facility.**

CHECK YES OR NO FOR EACH SPECIAL PROGRAM TYPE

	YES	NO
a. Specially designed program to treat children who are severely emotionally disturbed (SED)	☐	☐
b. Specially designed program to treat adults with severe and persistent mental illness (SPMI)	☐	☐
c. Specially designed program to treat seniors with Alzheimer's/ dementia	☐	☐
d. Specially designed program to treat persons with co-occurring mental illness and substance abuse disorders	☐	☐
e. Specially designed program to treat forensic (referred from your State's judicial system) client/patients	☐	☐
f. Specially designed programs to treat post-traumatic stress disorder	☐	☐
g. Other special program; please specify:	☐	☐

***13. Does this facility provide mental health services for the hearing-impaired?**

☐ Yes

☐ No

***14. In what languages does staff provide mental health services at this facility?**

CHECK ALL THAT APPLY

a. ☐ English

b. ☐ Spanish

c. ☐ Other; please specify:

CMHS FACILITY ID

15. Indicate whether the following quality assurance practices are in place at this facility?

CHECK YES OR NO FOR EACH PRACTICE

	YES	NO
a. Required continuing education for staff	☐	☐
b. Regularly scheduled case review with a supervisor	☐	☐
c. Regularly scheduled case review by an appointed quality review committee	☐	☐
d. Client/patient outcome follow-up after discharge	☐	☐
e. Periodic utilization review	☐	☐
f. Periodic client/patient satisfaction surveys	☐	☐

16. In the 12-month period beginning January 1, 2007, and ending December 31, 2007:

	YES	NO
a. Have staff at this facility used seclusion or restraint practices with clients?	☐	☐
b. Has training been provided to staff at this facility on alternatives to seclusion and restraint practices?	☐	☐

SECTION B: GENERAL FACILITY CHARACTERISTICS

17. Sometimes there is a reason (e.g., the facility is primarily a residence) when a mental health facility would not want to be listed in a public directory. Indicate below whether this facility (*the facility listed in the Facility Information Box on the front cover of the questionnaire*) should, or should not, be published in SAMHSA's online *Mental Health Services Locator*?

CHECK ONE ONLY

☐ Publish

☐ Do not publish; please explain:

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Questions? Call 1-800-722-6194

***18. Check one box below that best describes this type of facility (the facility listed in the Facility Information Box on the front cover of the questionnaire).** *Use the yellow information sheet, Mental Health Facilities Type Definitions, to classify this facility correctly.*

CHECK ONE ONLY

- ☐ Psychiatric hospital
- ☐ Residential treatment center for emotionally disturbed children
- ☐ Residential treatment center for adults
- ☐ Separate psychiatric unit of a general hospital
- ☐ Outpatient/partial care mental health facility
- ☐ Multi-setting (non-hospital) mental health facility
- ☐ Other; please specify:

***19. This facility is owned by:**

CHECK ONE ONLY

- ☐ A private partnership
- ☐ A private corporation
- ☐ State mental health agency (SMHA)
- ☐ State government (e.g., Department of Health) other than the SMHA
- ☐ Regional/district (e.g., hospital district authority)
- ☐ County government
- ☐ City or municipal government
- ☐ Other; please describe:

20. Is this facility part of a <u>for-profit</u> or part of a <u>non-profit</u> organization?

CHECK ONE ONLY

- ☐ For-profit
- ☐ Non-profit (includes not-for-profit)

***21. Is this facility affiliated with a religious organization?**

- ☐ Yes; please specify:
- ☐ No

22. Does this facility use a sliding fee scale? *Note that the answer to this question will not be published in SAMHSA's online Mental Health Services Locator.*

- ☐ Yes
- ☐ No

23. Does this facility offer treatment at no charge to client/patients who cannot afford to pay? *Note that the answer to this question will not be published in SAMHSA's online Mental Health Services Locator.*

- ☐ Yes
- ☐ No

24. Which of the following types of client/patient payments (direct or indirect) or insurance are accepted by this facility for mental health services?

CHECK ALL THAT APPLY

- **a.** ☐ Medicaid
- **b.** ☐ Medicare
- **c.** ☐ State mental health agency (or equivalent) funds
- **d.** ☐ Other state government funds; specify:
- **e.** ☐ Local government funds
- **f.** ☐ Other public funds; specify:
- **g.** ☐ Community Service Block Grants
- **h.** ☐ Community Mental Health Block Grants
- **i.** ☐ Other Federal block grants; specify:
- **j.** ☐ Client/patient fees
- **k.** ☐ Private Insurance
- **l.** ☐ Other private funds; specify:

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Questions? Call 1-800-722-6194

25. Does this facility provide mental health treatment services through any managed care organizations (MCOs)?

- *Managed care plans have arrangements with certain health care providers who give services to plan members, usually at discounted rates. Examples include managed behavioral healthcare organizations (MBHOs), health maintenance organizations (HMOs), and preferred provider organizations (PPOs).*

☐ Yes - Continue with Q25a

☐ No - Skip to Q26

***25a. What is the main MCO through which your facility provides mental health treatment services? Please specify:**

***26. Does this facility have licensing, certification, or accreditation from any of the following organizations?**

- *Include only licensing, accreditation, etc., related to the provision of behavioral health services.*
- *Do not include general business licenses, fire marshal approvals, personal-level credentials, food service licenses, etc.*

CHECK YES OR NO FOR EACH CATEGORY

	YES	NO
a. State mental health agency	☐	☐
b. State substance abuse agency	☐	☐
c. State department of health	☐	☐
d. Hospital licensing authority	☐	☐
e. JCAHO (*Joint Commission on Accreditation of Healthcare Organizations*)	☐	☐
f. CARF (*Commission on Accreditation of Rehabilitation Facilities*)	☐	☐
g. NCQA (*National Committee for Quality Assurrance*)	☐	☐
h. COA (*Council on Accreditation for Children & Family Services*)	☐	☐
i. Another state or local agency or other organization; please specify:	☐	☐

CMHS FACILITY ID

27. If available, enter the National Provider Identifier (NPI) for this facility.

NPI

SECTION C: CLIENT/PATIENT COUNTS

IMPORTANT: Questions in this section ask for counts at different time periods, e.g., the single day of December 31, 2007, the month of December 2007, the last 90 days before December 31, 2007, and the full 12-month period ending on December 31, 2007. Please pay close attention to the time period specified in each question. If the counts are not available for December 31, 2007, use the last day of the most recent month for which data are available.

Include in your counts all client/patients receiving mental health treatment, even if mental health is their secondary diagnosis or if a mental illness has not yet been formally determined.

28. For the client/patient counts requested in this section, indicate below the number of facilities that are included in your counts. Although counts for this facility only are preferred, it may be that you are unable to break your data down into separate facilities.

☐ Only this facility

☐ This facility plus others

This Facility	1
+ Additional Facilities	
= Total Facilities	

When we receive your questionnaire, we will contact you for a list of the other facilities included in your client counts.

IMPORTANT: The questions in this section ask for counts or percents based on the service settings you checked in question 1 at the beginning of the questionnaire.

If you checked 24-Hour Hospital Inpatient Setting, complete Section C1.

If you checked 24-Hour Residential Care Setting, complete Section C2.

If you checked Less than 24-Hour Outpatient/Partial Care Setting, complete Section C3.

Section C4 (and the remainder of the questionnaire) should be completed by all mental health providers.

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SECTION C1: 24-HOUR HOSPITAL INPATIENT CARE SETTING

29. On December 31, 2007, did any client/patients receive mental health services in a 24-hour hospital inpatient care setting <u>at this facility</u> (the facility listed in the Facility Information Box on the front cover of the questionnaire)?

☐ **Yes → ANSWER QUESTIONS 29a, 29b, AND 29c**

☐ **No → SKIP TO QUESTION 30**

29a. On December 31, 2007, how many client/patients received mental health services in a 24-hour hospital inpatient care setting <u>at this facility</u>?

- ***DO NOT*** count family members, friends, or other non-treatment client/patients

HOSPITAL INPATIENT TOTAL BOX ☐☐☐☐

29b. For each category below enter <u>either</u> the number <u>or</u> the percent of client/patients from the HOSPITAL INPATIENT TOTAL BOX in Question 29a.

Using the total number of client/patients specified in Question 29a, please give a breakdown of the client/patient population for each category below. You may use numbers (#) **OR** percents (%). Numbers in each box should add to the total in Question 29a. Percents should add to 100%.

USE NUMBERS (#) <u>OR</u> PERCENTS (%)

	#	%
SEX		
Male	☐☐☐☐	☐☐☐
Female	☐☐☐☐	☐☐☐
	TOTAL= Q29a	**100%**
AGE	#	%
0-17	☐☐☐☐	☐☐☐
18-64	☐☐☐☐	☐☐☐
65 & up	☐☐☐☐	☐☐☐
	TOTAL= Q29a	**100%**
ETHNICITY	#	%
Hispanic	☐☐☐☐	☐☐☐
Non-Hispanic	☐☐☐☐	☐☐☐
	TOTAL= Q29a	**100%**
RACE	#	%
White	☐☐☐☐	☐☐☐
Black	☐☐☐☐	☐☐☐
American Indian or Alaskan Native	☐☐☐☐	☐☐☐
Asian or Pacific Islander	☐☐☐☐	☐☐☐
Mixed Race	☐☐☐☐	☐☐☐
	TOTAL= Q29a	**100%**
LEGAL STATUS	#	%
Voluntary	☐☐☐☐	☐☐☐
Involuntary, non-forensic	☐☐☐☐	☐☐☐
Involuntary, forensic	☐☐☐☐	☐☐☐
	TOTAL= Q29a	**100%**

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29c. **On December 31, 2007, how many hospital inpatient beds <u>at this facility</u> were set up and staffed for the provision of mental health services?**

ENTER A NUMBER (IF NONE WERE SET UP ON DECEMBER 31, ENTER "0")

Number of beds

SECTION C2: 24-HOUR RESIDENTIAL CARE SETTING

30. **On December 31, 2007, did any client/patients receive mental health services in a 24-hour residential care setting <u>at this facility</u> (the facility listed in the Facility Information Box on the front cover of the questionnaire)?**

☐ **Yes → ANSWER QUESTIONS 30a, 30b, AND 30c**

☐ **No → SKIP TO QUESTION 31**

30a. **On December 31, 2007, how many client/patients received mental health services in a 24-hour residential care setting <u>at this facility</u>?**

- ***DO NOT*** count family members, friends, or other non-treatment client/patients

RESIDENTIAL TOTAL BOX

30b. **For each category below enter <u>either</u> the number <u>or</u> the percent of client/patients from the RESIDENTIAL TOTAL BOX in Question 30a.**

Using the total number of client/patients specified in Question 30a, please give a breakdown of the client/patient population for each category below. You may use numbers (#) **OR** percents (%). Numbers in each box should add to the total in Question 30a. Percents should add to 100%.

USE NUMBERS (#) <u>OR</u> PERCENTS (%)

	#	%
SEX		
Male		
Female		
	TOTAL= Q30a	**100%**
AGE	#	%
0-17		
18-64		
65 & up		
	TOTAL= Q30a	**100%**
ETHNICITY	#	%
Hispanic		
Non-Hispanic		
	TOTAL= Q30a	**100%**
RACE	#	%
White		
Black		
American Indian or Alaskan Native		
Asian or Pacific Islander		
Mixed Race		
	TOTAL= Q30a	**100%**
LEGAL STATUS	#	%
Voluntary		
Involuntary, non-forensic		
Involuntary, forensic		
	TOTAL= Q30a	**100%**

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30c. On December 31, 2007, how many residential beds <u>at this facility</u> were set up and staffed for the provision of mental health services?

ENTER A NUMBER (IF NONE WERE SET UP ON DECEMBER 31, ENTER "0")

Number of beds

SECTION C3: LESS THAN 24-HOUR OUTPATIENT/PARTIAL CARE SETTING

31. During the <u>month</u> of December 2007, did any client/patients receive mental health services in an outpatient care setting <u>at this facility</u> (the facility listed in the Facility Information Box on the front cover of the questionnaire)?

☐ **Yes → ANSWER QUESTIONS 31a AND 31b**

☐ **No → SKIP TO QUESTION 32**

31a. As of December 31, 2007, how many active client/patients were enrolled for services in an outpatient care setting <u>at this facility</u>?

An active outpatient client/patient is someone who: (1) was seen at this facility at least once during the 90 days before December 31, 2007;

AND

(2) was still enrolled in treatment on December 31, 2007.

- ***DO NOT*** count family members, friends, or other non-treatment client/patients

OUTPATIENT TOTAL BOX

31b. For each category below enter <u>either</u> the number <u>or</u> the percent of client/patients from the OUTPATIENT TOTAL BOX in Question 31a.

Using the total number of client/patients specified in Question 31a, please give a breakdown of the client/patient population for each category below. You may use numbers (#) **OR** percents (%). Numbers in each box should add to the total in Question 31a. Percents should add to 100%.

USE NUMBERS (#) <u>OR</u> PERCENTS (%)

	#	%
SEX		
Male		
Female		
	TOTAL= Q31a	**100%**
AGE	#	%
0-17		
18-64		
65 & up		
	TOTAL= Q31a	**100%**
ETHNICITY	#	%
Hispanic		
Non-Hispanic		
	TOTAL= Q31a	**100%**
RACE	#	%
White		
Black		
American Indian or Alaskan Native		
Asian or Pacific Islander		
Mixed Race		
	TOTAL= Q31a	**100%**
LEGAL STATUS	#	%
Voluntary		
Involuntary, non-forensic		
Involuntary, forensic		
	TOTAL= Q31a	**100%**

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SECTION C4: ALL MENTAL HEALTH CARE SETTINGS

32. Approximately what percent of the mental health treatment client/patients enrolled on December 31, 2007, at the facility listed in the Facility Information Box on the front cover of the questionnaire, had a diagnosed co-occurring mental health and substance abuse disorder?

PERCENT OF CLIENT/PATIENTS _____ %
(IF NONE, ENTER "0")

33. In the 12-month period beginning January 1, 2007, and ending December 31, 2007, what was the total number of admissions, readmissions, and transfers to this facility that received mental health treatment? *Count every admission and re-admission in this 12-month period. If a person was admitted 3 times, count this as 3 admissions. Exclude returns from unauthorized absence (escape, AWOL, elopement).*

- *FOR OUTPATIENT CLIENT/PATIENTS, consider an admission to be the initiation of a course of treatment. Count admissions into treatment, not individual treatment visits.*
- *IF DATA FOR THIS TIME PERIOD are not available, use the most recent 12-month period for which data are available.*
- *Count all admissions in which client/patients received mental health treatment, even if mental health was their secondary diagnosis.*

NUMBER OF MENTAL HEALTH ADMISSIONS IN 12-MONTH PERIOD ☐

34. Of the total number of admissions listed in the box above, what proportion were military veterans?

Please give your best estimate _____ %

☐ Data collected but not available

☐ Data not collected

SECTION D: COMMENTS

Please use the box below to elaborate on any of the information requested or provided in this questionnaire. Use additional sheets of paper if more space is needed. If applicable, indicate the number of the question to which your comments refer.

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SECTION E: CONTACT INFORMATION

Person Responsible for Completing This Survey

CHECK ONE ONLY

☐ Ms. ☐ Miss ☐ Mrs. ☐ Mr. ☐ Dr. ☐ Other; please specify:

First Name

Last Name

Title

Email Address

Phone Number

( ) - -

Extension

Fax Number

( ) - -

Thank you for your participation. Please return this questionnaire in the envelope provided. If you no longer have the envelope, please mail this questionnaire to:

Social & Scientific Systems, Inc.
P.O. Box 8548
Silver Spring, MD 20907-9907

CMHS FACILITY ID