Attachment A3

Augmentation screener questionnaire

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

OMB No: 0930-xxxx
APPROVAL EXPIRES: xx/xx/xxxx

2010 N-SSATS AUGMENTATION SCREENER

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

DATE: |__|__| / |__|__| **2010**
MONTH DAY

FINAL STATUS: |___|___|___|

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

001 = COMPLETE	008 = INELIGIBLE
004 = PHYSICALLY CLOSED	024 = DUPLICATE FACILITY
005 = CAN'T LOCATE	034 = MERGED FACILITY
006 = NO PARTICIPATION (EFFORT ENDED)	044 = NO SUBSTANCE ABUSE TREATMENT
007 = REFUSED	054 = SATELLITE FACILITY
	072 = HALFWAY HOUSE ONLY 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 <u>NOT</u> PROVIDED, CHECK THIS BOX ☐ ***SKIP TO "END" (PAGE 4)***

1 ☐ WRONG NUMBER ➜ ***PLACE IN LOCATING BASKET***

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

3 ☐ APPROPRIATE RESPONDENT; NEEDS CALLBACK ➜

4 ☐ NOT APPROPRIATE RESPONDENT

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.

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 <u>NOT</u> PROVIDED, CHECK THIS BOX ☐ SKIP TO "END" (PAGE 4)

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 ADDRESS CHANGE?

1 ☐ YES

0 ☐ NO → ***SKIP TO B2d***

B2b. Is there another substance abuse treatment facility in your organization that is currently located at [LOCATION ADDRESS]?

1 ☐ YES → **B2b.1 We need to collect information about that specific location. Could you give me the TELEPHONE number for that location?**
(_____) **-** _____ -_____ _____

0 ☐ NO → ***SKIP TO B2d***

B2c. INTERVIEWER: SKIP TO END. CROSS OUT RESPONSE TO B2 ON SCREENER. UPDATE CONTACT SHEET WITH NEW TELEPHONE NUMBER. CALL THIS NUMBER AND BEGIN WITH A1.

B2d. INTERVIEWER: DID THE FACILITY NAME CHANGE?

1 ☐ YES

0 ☐ NO → ***SKIP TO B3***

B2e. Was this facility ever called [FACILITY NAME]?

1 ☐ YES → ***SKIP TO B3***

0 ☐ NO

B2f. Does this facility provide substance abuse treatment services at this location?

1 ☐ YES

0 ☐ NO → ***GO TO END***

B2g. **INTERVIEWER: COMPLETE "NEW FACILITY SHEET" WHILE RESPONDENT IS ON THE PHONE. THEN, SKIP TO END. CODE A1 ON SCREENER AS 'WRONG NUMBER'. PLACE SCREENER AND CONTACT SHEET IN LOCATING BASKET, AND "NEW FACILITY SHEET" IN RECEIPT CONTROL BASKET.**

B3. **Does this facility, that is, the facility located at [LOCATION ADDRESS], have a licensed, certified or accredited substance abuse treatment program or unit at this address?**

1 ☐ YES

0 ☐ NO → ***SKIP TO B4a***

B4. **Which of the following substance abuse services are offered by <u>this</u> facility, that is, the facility located at [LOCATION ADDRESS]?**

PROBE IF NECESSARY: Please report for <u>only</u> this location.

		MARK "YES" OR "NO" FOR EACH	
		YES	NO
1.	**Intake, assessment, or referral**	1 ☐	0 ☐
2.	**Detoxification**.....	1 ☐	0 ☐
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 ☐	0 ☐

B4a. **Does this facility operate a halfway house or other transitional housing for substance abuse clients at this location?**

1 ☐ YES

0 ☐ NO

B4b. **INTERVIEWER: DID THE RESPONDENT ANSWER "YES" TO DETOXIFICATION OR SUBSTANCE ABUSE TREATMENT IN B4 ABOVE (CATEGORIES 2 or 3) OR "YES" TO HALFWAY HOUSE IN B4a?**

1 ☐ YES

0 ☐ NO → ***SKIP TO END (FINAL STATUS CODE "044")***

B5. **Is [LOCATION ADDRESS] also the mailing address for this facility?**

1 ☐ YES → ***SKIP TO B6***

0 ☐ NO

B5a. **What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?**

NAME:_____

STREET:_____

CITY/TOWN: _____ STATE:_____ ZIP:_____

B6. Does [FACILITY NAME] have a FAX number?

1 ☐ YES → **B6a. What is that FAX number?** (_____) **-** _____ -_____

0 ☐ NO

B7. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Finally, who is the facility director for [FACILITY]? (RECORD BELOW)

_____

END: Those are all the questions I have. Thank you very much for your time.

INTERVIEWER: FINAL STATUS AND PLACE IN COMPLETED BASKET.

NOTES: