U.S. Department of Health and Human Services Attachment A.1 (N-MHSS-Locator Questionnaire)

 OMB No. 0930-0119

 APPROVAL EXPIRES: xx/xx/xxxx

 See OMB burden statement on last page

**2012 National Mental Health Services Survey**

**(N-MHSS)**

**Locator Survey**

**Substance Abuse and Mental Health Services Administration**

***INSTRUCTIONS***

***PLEASE READ THIS ENTIRE PAGE BEFORE COMPLETING THE QUESTIONNAIRE***

* Most of the questions in this survey ask about “this facility”. By “this facility” we mean **[Facility Name 1], [Facility Name 2], [Location Address 1], [Location Address 2], [Location City, State, Zip]**. If you have any questions about how the term “this facility” applies to your facility, please call the N-MHSS helpline at 1‑866‑778-9752.
* Please answer ONLY for **[Facility Name 1], [Facility Name 2], [Location Address 1], [Location Address 2], [Location City, State, Zip]**, unless otherwise specified in the questionnaire.
* If this facility is a separate psychiatric unit of a general hospital, consider the psychiatric unit as the relevant “facility” for the purpose of this survey.
* Please keep a copy of your completed Web questionnaire for your records. You will be given the opportunity to review and print your responses at the end of the questionnaire.
* For additional information about this survey and definitions of some of the terms used, please visit our website at http://info.nmhss.org.
* If you have questions, please contact:

**mathematica policy research**

**1-866-778-9752**

**prepared by mathematica policy research**

***IMPORTANT INFORMATION***

* **Asterisked Questions.** Information from asterisked (**\***) questions is published in SAMHSA’s online Mental Health Facility Locator at http://store.samhsa.gov/MHLocator, unless you designate otherwise in question A18 of this questionnaire
* **Mapping Feature in Locator.** Complete and accurate name and address information is needed for SAMHSA’s online Mental Health Facility Locator so it can correctly map the facility’s location
* **Eligibility for Locator.** Only facilities that provide mental health treatment services and complete this questionnaire are eligible to be listed in the online Mental Health Facility Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1‑866‑778-9752

**prepared by mathematica policy research**

|  |
| --- |
| SECTION A: FACILITYCHARACTERISTICS |

 **A1. Does this facility, at this location, offer:**

The following questions ask about the services currently offered at this facility only, that is, [Facility Name 1], [Facility Name 2] located at [Location Address 1], [Location Address 2], [Location City, State, Zip].

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Mental health intake services 1 🞎 0 🞎

 2. Mental health diagnostic evaluation 1 🞎 0 🞎

 3. Mental health information and 1 🞎 0 🞎

 referral services *(also includes emergency programs that provide services in person or by telephone*)

 4. Mental health treatment services 1 🞎 0 🞎

 *(services focused on improving the*

 *mental well-being of individuals with*

 *mental disorders and on promoting their*

 *recovery)*

 5. Substance abuse treatment services 1 🞎 0 🞎

 6. Administrative services 1 🞎 0 🞎

 **A2. Did you answer “yes” to mental health treatment services in question A1 above (option 4)?**

 1 🞎 Yes

 0 🞎 No **SKIP TO B1 (PAGE 4)**

**\*A3. In which of these settings are mental health treatment services offered at this facility, at this location?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. **24-hour hospital inpatient setting** 1 🞎 0 🞎

 (psychiatric hospital or general hospital

 with a separate psychiatric unit)

 2. **24-hour residential setting** 1 🞎 0 🞎

 (24-hour, overnight, psychiatric care in

 a residential non-inpatient setting such

 as a residential treatment center for adults

 or children)

 3. **Day treatment or partial**

 **hospitalization setting** 1 🞎 0 🞎

 (structured programs of treatment, activity,

 or other mental health services provided in

 clusters of 3 or more hours per day)

 4. **Outpatient mental health setting** 1 🞎 0 🞎

 (programs of mental health services

 provided to clients on an hourly schedule,

 on an individual or group basis)

**\*A4. Which ONE category best describes this facility, at this location?**

* + - * *For definitions of facility types, log on to:* [*http://info.nmhss.org*](http://info.nmhss.org)

 **MARK ONE ONLY**

 1 🞎 Psychiatric hospital

**SKIP TO A6**

**(PAGE 2)**

 2 🞎 Separate inpatient psychiatric

 unit of a general hospital

 (c*onsider this psychiatric unit*

 *as the relevant “facility” for the*

 *purpose of this survey)*

 3 🞎 Residential treatment center

 for children

 4 🞎 Residential treatment center

 for adults

 5 🞎 Outpatient or day treatment or partial

 hospitalization mental health

 facility

 6 🞎 Multi-setting mental health facility (non-hospital residential plus outpatient or day treatment or partial hospitalization)

 7 🞎 Other *(Specify*:

 *)*

 **A5. Is this facility a solo practice or small group practice?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A6**

 **A5a. Is this facility licensed or accredited as a mental health clinic or mental health center?**

* + - * *Do not count the licenses or credentials of individual practitioners.*

 1 🞎 Yes

 0 🞎 No **SKIP TO B1 (PAGE 4)**

 **A6. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?**

 1 🞎 Yes **SKIP TO B1 (PAGE 4)**

 0 🞎 No

**\*A7.** **Is this facility operated by:**

 **MARK ONE ONLY**

 1 🞎 A private for-profit organization

 2 🞎 A private non-profit organization

 3 🞎 State mental health agency (SMHA)

 4 🞎 Other state government agency or department

 (e.g., Department of Health)

 5 🞎 Regional/district authority or local, county

 or municipal government

 6 🞎 Tribal government

 7 🞎 U.S. Federal agency

 **MARK ONE ONLY**

 a 🞎 Department of Veterans Affairs

 b 🞎 Department of Defense

 c 🞎 Indian Health Service

 d 🞎 Other Federal agency *(Specify*:

 *)*

 8 🞎 Other *(Specify*: *)*

**\*A8. Does this facility, at this location, provide treatment services that specifically address:**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Schizophrenia or other psychoses 1 🞎 0 🞎

 2. Mood disorders (e.g., bipolar, 1 🞎 0 🞎

 depression)

 3. Autism/autism spectrum disorders 1 🞎 0 🞎

 4. Attention deficit or conduct disorders 1 🞎 0 🞎

 (e.g., ADHD, disruptive behavior

 disorder)

 5. Anxiety disorders (e.g., PTSD, 1 🞎 0 🞎

 obsessive-compulsive disorder,

 phobia disorder)

 6. Eating disorders (e.g., anorexia 1 🞎 0 🞎

 nervosa, bulimia)

 7. Other *(Specify* 1 🞎 0 🞎

 *)*

**\*A9. What age groups are accepted for treatment at this facility?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Children (aged 17 or younger) 1 🞎 0 🞎

 2. Young adults (18-25) 1 🞎 0 🞎

 3. Adults (26 or older) 1 🞎 0 🞎

**\*A10. This question has two parts.**

 **Column A –** Please indicate the types of clients treated at this location.

 **Column B –** For each “yes” in Column A, indicate whether this facility offers a specially-designed mental health treatment program or group exclusively for that type of client.

|  |  |  |
| --- | --- | --- |
|  | Column A | Column B |
|  **Type of Client** | **Clients Treated** | **Offers** **Specially Designed Program or Group** |
|  | YES | NO | YES | NO |
|  1. Children with serious emotional disturbance (SED) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  2. Adults with serious mental illness (SMI) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  3. Seniors or older adults | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  4. Individuals with Alzheimer’s or dementia | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  5. Individuals with co-occurring mental and substance abuse disorders | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  6. Individuals with post-traumatic stress disorder (PTSD) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  7. Veterans | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  8. Active duty military | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
|  9. Members of military families | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 10. Individuals with traumatic brain injury (TBI) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 11. Lesbian, gay, bisexual, transgender, or questioning clients (LGBTQ) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 12. Forensic clients (referred from the court/judicial system) | 1 🞎 | 0 🞎 | 1 🞎 | 0 🞎 |
| 13. Other special program |  |  | 1 🞎 | 0 🞎 |
|  (*Specify below:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)* |

**\*A11. Which of these services are offered at this facility, at this location?**

* + - * *For definitions of these services, log on to:* [*http://info.nmhss.org*](http://info.nmhss.org)

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Consumer-run (peer support) services 1 🞎 0 🞎

 2. Psychiatric emergency walk-in services 1 🞎 0 🞎

 3. Telemedicine therapy 1 🞎 0 🞎

**\*A12. Does this facility offer mental health services for the hearing-impaired?**

 1 🞎 Yes

 0 🞎 No

**\*A13. Does this facility provide mental health treatment services in a language other than English at this location?**

 1 🞎 Yes

 0 🞎 No, only English **SKIP TO A14**

**\*A13a. In what other languages do staff provide mental health treatment services at this facility?**

* + - * *Do not count languages provided only by on-call interpreters.*

 **MARK ALL THAT APPLY**

**American Indian or Alaska Native:**

 1 🞎 Hopi 4 🞎 Ojibwa

 2 🞎 Lakota 5 🞎 Yupik

 3 🞎 Navajo

 6 🞎 Other Native American Indian or Alaska Native

 language

 *(Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)

**Other Languages:**

 1 🞎 Arabic 9 🞎 Japanese

 2 🞎 Any Chinese Language 10 🞎 Korean

 3 🞎 Creole 11 🞎 Polish

 4 🞎 French 12 🞎 Portuguese

 5 🞎 German 13 🞎 Russian

 6 🞎 Greek 14 🞎 Spanish

 7 🞎 Hmong 15 🞎 Tagalog

 8 🞎 Italian 16 🞎 Vietnamese

 17 🞎 Any other language *(Specify:*

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*)*

**\*A14. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A15**

 **A14a. Do you want the availability of free care for eligible clients published in SAMHSA’s online Mental Health Facility Locator?**

* + - * *The Locator will inform potential clients to call the facility for information on eligibility.*

 1 🞎 Yes

 0 🞎 No

**\*A15. Does this facility use a sliding fee scale?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A16**

 **A15a. Do you want the availability of a sliding fee scale published in SAMHSA’s online Mental Health Facility Locator?**

* + - * *The Locator will explain that sliding fee scales are based on income and other factors.*

 1 🞎 Yes

 0 🞎 No

**\*A16. Which of the following types of client payments or insurance are accepted by this facility for mental health treatment services?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Medicaid 1 🞎 0 🞎

 2. Medicare 1 🞎 0 🞎

 3. State-financed health insurance plan

 other than Medicaid 1 🞎 0 🞎

 4. Federal military insurance

 (e.g., TRICARE) 1 🞎 0 🞎

 5. Cash or self-payment

 (i.e., out-of-pocket) 1 🞎 0 🞎

 6. Private health insurance 1 🞎 0 🞎

 7. IHS/638 contract care funds 1 🞎 0 🞎

**\*A17. What telephone number(s) should a potential client call to schedule a mental health intake appointment at this facility?**

 INTAKE TELEPHONE NUMBER(S):

 1. (\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_\_

 2. (\_\_\_\_) \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_\_

 **A18. Information from asterisked questions will be published in SAMHSA’s online Mental Health Facility Locator. If eligible, does this facility want to be listed in the Locator?**

* + - * *The Mental Health Facility Locator can be found at* <http://store.samhsa.gov/MHLocator>

 1 🞎 Yes

 0 🞎 No

**A19. Does this facility have a website or web page with information about the facility’s mental health treatment programs?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A20**

**\*A19a**. **What is this facility’s website address?**

* + - * *Please enter the address exactly as it should be entered in order to access your site.*

Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A20. Does this facility have a National Provider Identifier (NPI) number?**

* + - * *Exclude the NPI numbers of individual practitioners and of groups of practitioners.*

 1 🞎 Yes

 0 🞎 No **SKIP TO B1 (PAGE 4)**

**A20a. What is the NPI number for this facility?**

* + - * *If the facility has more than one NPI number, please provide only the primary number.*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NPI** |  |  |  |  |  |  |  |  |  |  |

|  |
| --- |
| SECTION B: CONTACT INFORMATION |

**B1. Who was primarily responsible for completing this form?** *This information will only be used if we need to contact you about your responses. It will not be published.*

 **MARK ONE ONLY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1 🞎 Ms. | 2 🞎 Miss | 3 🞎 Mrs. | 4 🞎 Mr. | 5 🞎 Dr. |

 6 🞎 Other *(Specify:* *)*

|  |  |
| --- | --- |
| **FIRST NAME:** |  |

|  |  |
| --- | --- |
| **LAST NAME:** |  |

|  |
| --- |
| **EMAIL ADDRESS:** |
|  |

|  |
| --- |
| **PHONE NUMBER:** |
|  **(** |  |  |  | **) -** |  |  |  | **-** |  |  |  |  |  |  |  |  |  |  |
|  | Area Code |  |  Extension |

|  |
| --- |
| **FAX NUMBER:** |
|  **(** |  |  |  | **) -** |  |  |  | **-** |  |  |  |  |  |  |  |  |  |  |
|  | Area Code |  |  Extension |
|  |  |  |

|  |
| --- |
| ***PLEDGE TO RESPONDENTS****The information you provide will be protected to the fullest extent allowable under Section 501(n) of the Public Health Service Act (42 USC 290aa(n)). This law permits the public release of identifiable information about an establishment only with the consent of that establishment and limits the use of the information to the purposes for which it was supplied. With the explicit consent of eligible treatment facilities, information provided in response to survey questions marked with an asterisk will be published in SAMHSA’s National Directory of Mental Health Treatment Facilities and the Mental Health Treatment Facility Locator. Responses to non-asterisked questions will be published only in statistical summaries so that individual treatment facilities cannot be identified.* |

Public Burden Statement: 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 control number for this project is 0930-0119. Public reporting burden for this collection of information is estimated to average 25 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to SAMHSA Reports Clearance Officer, 1 Choke Cherry Road, Room 8-1099, Rockville, Maryland 20857.