U.S. Department of Health and Human Services OMB No: 0930-xxxx

 APPROVAL EXPIRES: xx/xx/xxxx

 See OMB burden statement on last page

BEHAVIORAL HEALTH SCREENER

Hello, I am calling on behalf of SAMHSA, the Substance Abuse and Mental Health Services Administration. I would like to ask you a few questions about your facility to update our behavioral health records.

**A1. First, I’d like to confirm that this is [FACILITY NAME], located at [LOCATION ADDRESS]. Is that correct?**

|  |
| --- |
| ***IF MENTAL HEALTH SERVICES OR SUBSTANCE ABUSE CLEARLY NOT PROVIDED, CHECK THIS BOX □* *SKIP TO “END” (PAGE 4)*** |

 1 □ YES, NAME AND ADDRESS CORRECT ***SKIP TO A3 (PAGE 2)***

0 □ NO, NAME AND/OR ADDRESS INCORRECT

**A2. RECORD CORRECT INFORMATION BELOW:**

 Name:

 Street:

 City/Town: State: ZIP:

**A2a. INTERVIEWER: DID THE ADDRESS CHANGE?**

 1 □ YES

 0 □ NO ***SKIP TO A2d***

**A2b. Is there another mental health treatment or substance abuse facility in your organization that is currently located at [LOCATION ADDRESS]?**

 1 □ YES

**A2b.1 We need to collect information about that specific location. Could you give me the TELEPHONE number for that location?**

 (\_\_\_\_\_\_\_) **-** \_\_\_\_\_\_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_\_\_

 Area Code

 0 □ NO ***SKIP TO A2d***

**A2c. INTERVIEWER: SKIP TO END.**

**A2d. INTERVIEWER: DID THE FACILITY NAME CHANGE?**

 1 □ YES

 0 □ NO ***SKIP TO A3 (PAGE 2)***

**A2e. Was this facility ever called [FACILITY NAME]?**

 1 □ YES ***SKIP TO A2f***

 0 □ NO ***SKIP TO A2g***

**A2f. Did this name change result in a new license number for this facility?**

 1 □ YES

 0 □ NO ***SKIP TO A3 (BELOW)***

**A2g. Does this facility provide mental health or substance abuse treatment services at this location?**

 1 □ YES

 0 □ NO ***GO TO END (PAGE 4)***

**A2h. INTERVIEWER: COLLECT NEW FACILITY INFORMATION WHILE RESPONDENT IS ON THE PHONE, THEN SKIP TO END.**

**A3. Does this facility, at this location, offer mental health treatment services (services focused on improving the mental well-being of individuals with mental disorders and on promoting their recovery)?**

 1 □ YES

 0 □ NO ***GO TO A10 (PAGE 3)***

**A4. What other mental health services do you offer, at this location?**

 **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 referral services 1 🞎 0 🞎

 *(also includes emergency programs that provide services*

 *in person or by telephone*)

 4. Administrative services 1 🞎 0 🞎

**A5. Is [LOCATION ADDRESS] (also) the mailing address for this mental health treatment facility?**

 1 □ YES ***SKIP TO A6 (BELOW)***

 0 □ NO

**A5a. What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?**

 Name:

 Street:

 City/Town: State: ZIP:

**A6. Does [FACILITY NAME] have a FAX number?**

 1 □ YES

**A6a. What is that FAX number?** (\_\_\_\_\_\_\_) **-** \_\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_

 Area Code

 0 □ NO

**A7. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the mental health facility director for [FACILITY]? (RECORD BELOW)**

**A8. Does [DIRECTOR NAME] or the person in charge of your mental health program have an EMAIL address?**

**A8a. What is that EMAIL address?**

**A8b. Name of Contact Person (if not Director)**

 1 □ YES

 0 □ NO

**A9. Does this mental health facility have a web site or web address? (IF YES, RECORD BELOW. IF NO, *GO TO A10*.)**

**A10. 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 A11a***

**A11. Which of the following substance abuse services are offered by this facility, at this location?**

 **PROBE IF NECESSARY: Please report for only 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 🞎

**A11a. Does this facility operate transitional housing or a halfway house for substance abuse clients at this location?**

1 □ YES

 0 □ NO

**A11b. Did this facility answer yes to either A11.2, A11.3, or A11a above? Please use the shaded boxes for reference.**

1 □ YES

 0 □ NO ***GO TO END (PAGE 4)***

**A12. Is [LOCATION ADDRESS] (also) the mailing address for this substance abuse treatment facility?**

 1 □ YES ***SKIP TO A13 (BELOW)***

 0 □ NO

**A12a. What is the mailing address for [FACILITY NAME] located at [LOCATION ADDRESS]?**

 Name:

 Street:

 City/Town: State: ZIP:

**A13. Does [FACILITY NAME] have a FAX number?**

 1 □ YES

**A13a. What is that FAX number?** (\_\_\_\_\_\_\_) **-** \_\_\_\_\_\_\_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_\_

 Area Code

 0 □ NO

**A14. ASK IF NEEDED, OTHERWISE, VERIFY AND RECORD WITHOUT ASKING: Who is the substance abuse facility director for [FACILITY]? (RECORD BELOW)**

**A15. Does [DIRECTOR NAME] or the person in charge of your substance abuse program have an EMAIL address?**

**A15a. What is that EMAIL address?**

**A15b. Name of Contact Person (if not Director)**

 1 □ YES

 0 □ NO

**A16. Does this substance abuse treatment facility have a web site or web address? (IF YES, RECORD BELOW. IF NO, *GO TO END*.)**

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

**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.

**NOTES:**

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-xxxx. Public reporting burden for this collection of information is estimated to average 5 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 2-1057, Rockville, Maryland 20857.