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.1We 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. <u>INTERVIEWER</u>: COLLECT NEW FACILITY INFORMATION WHILE RESPONDENT IS ON THE PHONE, THEN SKIP TO END.

A3. Does this facility, <u>at this location</u>, 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, <u>at this location</u>?

		MARK "YES" OR "NO" FOR EACH	
		<u>YES</u>	<u>NO</u>
1.	Mental health intake services	1☐	0☐
2.	Mental health diagnostic evaluation	1☐	0☐
3.	Mental health information and referral services *(also includes emergency programs that provide services in person or by telephone)*	1☐	0☐
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?

1☐ YES → **A8a.What is that EMAIL address?**

0☐ NO **A8b.Name of Contact Person (if not Director)**

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

_____

A10. Does <u>this</u> 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 <u>this</u> facility, <u>at this location</u>?

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

		MARK "YES" OR "NO" FOR EACH	
		<u>YES</u>	<u>NO</u>
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 <u>this</u> 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?

1☐ YES → **A15a.What is that EMAIL address?**

0☐ NO **A15b.Name of Contact Person (if not Director)**

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:

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_____

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.