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

 APPROVAL EXPIRES: XX/XX/20XX

 See OMB burden statement on last page

**2015 National Mental Health Services Survey**

**(N-MHSS)**

**Locator Survey**

Substance Abuse and Mental Health Services Administration (SAMHSA)

***PLEASE REVIEW THE FACILITY INFORMATION PRINTED ABOVE.***

***CROSS OUT ERRORS AND ENTER CORRECT OR MISSING INFORMATION.***

CHECK ONE

* Information is complete and correct, no changes needed
* All missing or incorrect information has been corrected

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



|  |
| --- |
| **Would you prefer to complete this questionnaire online?** See the blue flyer enclosed in your questionnaire packet for the Internet address and your unique user ID and password. You can log on and off the website as often as needed to complete the questionnaire. When you log on again, the program will take you to the next unanswered question. If you need additional help or information, call the N-MHSS helpline at 1-866-778-9752. |

***INSTRUCTIONS***

* Most of the questions in this survey ask about “this facility.” By “this facility” we mean the specific treatment facility or program whose name and location are printed on the front cover. If you have any questions about how the term “this facility” applies to your facility, please call 1-866-778-9752.
* Please answer ONLY for the specific facility or program whose name and location are printed on the front cover, unless otherwise specified in the questionnaire.
* If this is **a separate inpatient psychiatric unit of a general hospital**, consider the psychiatric unit as the relevant “facility” for the purpose of this survey.
* For additional information about the survey and definitions for some of the terms, please visit our website at: **http://info.nmhss.org**.
* **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.
* If you have questions, contact:

mathematica policy research

1-866-778-9752

NMHSS@mathematica-mpr.com

***IMPORTANT INFORMATION***

**\* Asterisked Questions.** Information from asterisked (**\***) questions is published in SAMHSA’s online Behavioral Health Treatment Services Locator, found at http://findtreatment.samhsa.gov, unless you designate otherwise in question B1, page 5 of this questionnaire.

**Mapping Feature in Locator.** Complete and accurate name and address information is needed for SAMHSA’s online Behavioral Health Treatment Services Locator so it can correctly map the facility’s location.

**Eligibility for Locator.**  Only facilities that provide mental health treatment and complete this questionnaire are eligible to be listed in the online Behavioral Health Treatment Services Locator. If you have any questions regarding eligibility, please contact the N-MHSS helpline at 1‑866‑778-9752.

**prepared by mathematica policy research**

**prepared by mathematica policy research**

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

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

**Section A asks about characteristics of individual facilities and should be completed for this facility only, that is, the treatment facility or program at the location listed on the front cover.**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Mental health intake 1 🞎 0 🞎

 2. Mental health diagnostic evaluation 1 🞎 0 🞎

 3. Mental health information and 1 🞎 0 🞎

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

 \*4. Mental health treatment 1 🞎 0 🞎

 *(interventions such as therapy or psychotropic medication that treat a person’s mental health problem or condition, reduce symptoms, and improve behavioral functioning and outcomes)*

 5. Substance abuse treatment 1 🞎 0 🞎

 6. Administrative services 1 🞎 0 🞎

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

 1 🞎 Yes

 0 🞎 No **SKIP TO B1 (PAGE 5)**

**\*A3. What levels of care are offered at this facility, at this location, for mental health treatment?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. 24-hour hospital inpatient care 1 🞎 0 🞎

 2. 24-hour residential care 1 🞎 0 🞎

 3. Less than 24-hour partial

 hospitalization 1 🞎 0 🞎

 4. Less than 24-hour outpatient care 1 🞎 0 🞎

**\*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

 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 only

**SKIP TO**

 **A6**

**(BELOW)**

 4 🞎 Residential treatment center for

 adults only

 5 🞎 Other residential treatment

 setting

 6 🞎 Veterans Administration medical

 center (VAMC)/facility

 7 🞎 Community mental health

 center

 8 🞎 Outpatient mental health facility

 9 🞎 Multi-setting mental health facility

 (non-hospital residential plus outpatient

 or partial hospitalization)

 10 🞎 Other *(Specify:*

 *)*

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

 1 🞎 Yes

 0 🞎 No **SKIP TO A6 (BELOW)**

 **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 B4 (PAGE 5)**

 **A6. Is this facility a Federally Qualified Health Center (FQHC)?**

* + - * *FQHCs include: (1) all organizations that receive grants under Section 330 of the Public Health Service Act; and (2) other organizations that have not received grants to date, but have met the requirements to receive grants under Section 330 according to the U.S. Department of Health and Human Services.*

 1 🞎 Yes

 0 🞎 No

 **A7. What is the primary treatment focus of this facility, at this location?**

* + - * *Separate psychiatric units in a general hospital should answer for just their unit and NOT for the entire hospital*

 **MARK ONE ONLY**

 1 🞎 Mental health treatment

 2 🞎 Substance abuse
treatment **SKIP TO B4 (PAGE 5)**

 3 🞎 Mix of mental health and substance abuse treatment (neither is primary)

 4 🞎 General health care

 5 🞎 Other service focus *(Specify:*

 *)*

**A8. Is this facility a jail, prison, or detention center that provides treatment exclusively for incarcerated persons or juvenile detainees?**

 1 🞎 Yes **SKIP TO B4 (PAGE 5)**

 0 🞎 No

**\*A9.** **Is this facility operated by:**

 **MARK ONE ONLY**

 1 🞎 A private for-profit organization

**SKIP TO**

**A10 (NEXT COLUMN)**

 2 🞎 A private non-profit organization

 3 🞎 A public agency or department

**\*A9a. Which public agency or department?**

 **MARK ONE ONLY**

 1 🞎 State mental health authority (SMHA)

 2 🞎 Other state government agency or department (e.g., Department of Health)

 3 🞎 Regional/district authority or local, county, or municipal government

 4 🞎 Tribal government

 5 🞎 Department of Veterans Affairs

 6 🞎 Indian Health Service

 7 🞎 Other *(Specify:*

 *)*

**\*A10. What age groups are accepted for treatment at this facility?**

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Children (17 or younger) 1 🞎 0 🞎

 2. Young adults (18-25) 1 🞎 0 🞎

 3. Adults (26-64) 1 🞎 0 🞎

 4. Seniors (65 or older) 1 🞎 0 🞎

**\*A11. Does this facility offer a mental health treatment program or group designed exclusively for:**

* + - * *If you treat these clients for mental health, but do not have a specifically tailored program or group for them, check "NO."*

 **MARK “YES” OR “NO” FOR EACH**

 YES NO

 1. Children with serious emotional

 disturbance (SED) 1 🞎 0 🞎

 2. Adults with serious mental

 illness (SMI) 1 🞎 0 🞎

 3. Seniors or older adults 1 🞎 0 🞎

 4. Persons with Alzheimer’s or

 dementia 1 🞎 0 🞎

 5. Persons with co-occurring mental

 and substance use disorders 1 🞎 0 🞎

 6. Persons with eating disorders 1 🞎 0 🞎

 7. Persons with HIV or AIDS 1 🞎 0 🞎

 8. Persons with post-traumatic

 stress disorder (PTSD) 1 🞎 0 🞎

 9. Veterans 1 🞎 0 🞎

 10. Active duty military 1 🞎 0 🞎

 11. Members of military families 1 🞎 0 🞎

 12. Persons with traumatic brain

 injury (TBI) 1 🞎 0 🞎

 13. Lesbian, gay, bisexual, or

 transgender clients (LGBT) 1 🞎 0 🞎

 14. Forensic clients (referred from

 the court/judicial system) 1 🞎 0 🞎

 15. Other special program *(Specify:* 1 🞎 0 🞎

 *)*

**\*A12. Which of these services are offered at this facility, at this location?**

* + - * *For definitions of these services, log on to: 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 🞎

 4. Crisis intervention team that

 handles acute mental health

 issues at this facility and/or

 offsite 1 🞎 0 🞎

**\*A13. Does this facility offer mental health treatment services for the hearing-impaired?**

 1 🞎 Yes

 0 🞎 No

**\*A14. 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 A15 (PAGE 4)**

**\*A14a. Do staff provide mental health treatment services in Spanish at this facility?**

 1 🞎 Yes

 0 🞎 No

 **A14b. Do staff at this facility provide mental health treatment services in any other languages?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A15 (PAGE 4)**

**\*A14c. 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

 2 🞎 Lakota

 3 🞎 Navajo

 4 🞎 Ojibwa

 5 🞎 Yupik

 6 🞎 Other Native American Indian or Alaska Native language

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

**Other Languages:**

 7 🞎 Arabic

 8 🞎 Any Chinese Language

 9 🞎 Creole

 10 🞎 French

 11 🞎 German

 12 🞎 Greek

 13 🞎 Hmong

 14 🞎 Italian

 15 🞎 Japanese

 16 🞎 Korean

 17 🞎 Polish

 18 🞎 Portuguese

 19 🞎 Russian

 20 🞎 Tagalog

 21 🞎 Vietnamese

 22 🞎 Any other language *(Specify:*

 *)*

**\*A15. Which statement(s) below BEST describe(s) this facility’s smoking policy for clients?**

 **MARK ONE ONLY**

 1 🞎 Not permitted to smoke anywhere outside or within any building

 2 🞎 Permitted in designated outdoor area(s)

 3 🞎 Permitted anywhere outside

 4 🞎 Permitted in designated indoor area(s)

 5 🞎 Permitted anywhere inside

 6 🞎 Permitted anywhere without restriction

**\*A16. Does this facility use a sliding fee scale?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A17**

 **A16a. Do you want the availability of a sliding fee scale published in SAMHSA’s online Behavioral Health Treatment Services Locator?**

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

 1 🞎 Yes

 0 🞎 No

**\*A17. Does this facility offer treatment at no charge to clients who cannot afford to pay?**

 1 🞎 Yes

 0 🞎 No **SKIP TO A18 (NEXT COLUMN)**

 **A17a. Do you want the availability of free care for eligible clients published in SAMHSA’s online Behavioral Health Treatment Services Locator?**

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

 1 🞎 Yes

 0 🞎 No

**\*A18. Which of the following types of client payments, insurance, or funding are accepted by this facility for mental health treatment services?**

 **MARK “YES” OR “NO” FOR EACH**

 DON’T

 YES NO KNOW

 1. Cash or self-payment 1 🞎 0 🞎 d 🞎

 2. Private health insurance 1 🞎 0 🞎 d 🞎

 3. Medicare 1 🞎 0 🞎 d 🞎

 4. Medicaid 1 🞎 0 🞎 d 🞎

 5. State-financed health insurance plan other than Medicaid 1 🞎 0 🞎 d 🞎

 6. State mental health agency (or equivalent) funds 1 🞎 0 🞎 d 🞎

 7. State welfare or child or family services agency funds 1 🞎 0 🞎 d 🞎

 8. State corrections or juvenile justice agency funds 1 🞎 0 🞎 d 🞎

 9. State education agency funds 1 🞎 0 🞎 d 🞎

 10. Other state government funds 1 🞎 0 🞎 d 🞎

 11. County or local government funds 1 🞎 0 🞎 d 🞎

 12. Community Service Block Grants 1 🞎 0 🞎 d 🞎

 13. Community Mental Health Block Grants 1 🞎 0 🞎 d 🞎

 14. Federal military insurance (such as TRICARE) 1 🞎 0 🞎 d 🞎

 15. U.S. Department of Veterans Affairs funds 1 🞎 0 🞎 d 🞎

 16. IHS/638 contract care funds 1 🞎 0 🞎 d 🞎

 17. Other *(Specify:* 1 🞎 0 🞎 d 🞎

 *)*

**\*A19. What telephone number(s) should a potential client call to schedule an intake appointment?**

 INTAKE TELEPHONE NUMBER(S):

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

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

|  |
| --- |
| SECTION B: GENERAL INFORMATION |

 **B1. If eligible, does this facility want to be listed in SAMHSA’s online Behavioral Health Treatment Services Locator?**

* + - * *The Locator can be found at* http://findtreatment.samhsa.gov

 1 🞎 Yes

 0 🞎 No

 **B2.** **Does this facility have a website or web page with information about the facility’s mental health treatment program(s)?**

 1 🞎 Yes

 0 🞎 No **SKIP TO B3 (BELOW)**

**\*B2a. What is this facility’s website address?**

* + - * *Please enter the address exactly as it should be entered in order to access your site.*
			* *Do not enter http:// (for example, enter www.yourfacility.com)*

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

 **B3. Does this facility have a National Provider Identifier (NPI) number?**

* + - * *Do not include the NPI numbers of individual practitioners and of groups of practitioners.*

 1 🞎 Yes

 0 🞎 No **SKIP TO B4 (NEXT COLUMN)**

 **B3a. What is the NPI number for this facility?**

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **NPI** |  |  |  |  |  |  |  |  |  |  |
|  | (*NPI is a 10-digit numeric ID*) |

 **B4. 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 🞎 Mrs. | 3 🞎 Mr. | 4 🞎 Dr. |

 5 🞎 Other *(Specify:* *)*

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

|  |  |
| --- | --- |
| **TITLE:** |  |

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

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

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

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

ANY ADDITIONAL COMMENTS

**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:**

**MATHEMATICA POLICY RESEARCH**

ATTN: RECEIPT CONTROL - Project 06667\_1

P.O. Box 2393

Princeton, NJ 08543-2393

|  |
| --- |
| ***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 Behavioral Health Treatment Services 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-XXX. 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 2-1057, Rockville, Maryland 20857.