OMB No. 0930-NEW
Expiration Date: XX/XX/XXXX

Zero Suicide Evaluation
Consumer Experiences Survey

Description of Participation: The Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services is conducting an evaluation to learn more about the kinds of care provided by healthcare organizations who have received a Zero Suicide grant, including your healthcare provider. SAMHSA is conducting this evaluation with help from Team Aptive. Team Aptive includes two research and evaluation companies, Aptive Resources and ICF, who are contracted by SAMHSA for the evaluation. We are asking you to complete two brief surveys – one now and another follow-up survey in about six months - to share your experiences with this healthcare provider. Each survey will take approximately 20-25 minutes to complete.

Rights Regarding Participation: Your participation in this survey is completely voluntary.

- There are no penalties or consequences to you if you do not participate.
- You may stop the survey or skip a question at any time for any reason.
- You may contact the evaluation project director with any questions you have before, during, or after completion.

Privacy: We will take every precaution to protect your privacy. All survey responses will be anonymous. Neither Team Aptive, your provider, nor SAMHSA will be able to identify you as a respondent.-

Benefits: Your participation in this interview will not result in any direct benefits to you. However, your input, along with input from other consumers, will help SAMHSA and your provider agency improve its suicide prevention programs.

Incentive: In appreciation of your time, you will receive a $15 electronic gift card for completing this survey the first time and a $20 electronic gift card after you complete the 6 month follow-up survey.

Risks: Some of the questions in this survey ask about services received during crisis situations. As a reminder, you may skip questions you do not wish to answer. If at any time you begin to feel upset while taking this survey, please stop the survey and contact 988 to speak to a counselor 24 hours a day/7 days a week.

Contact Information: If you have any concerns about completing this survey or have any questions about the study, please contact Christine Walrath, principal investigator, at (646) 695-8154 or christine.walrath@icf.com.

For any questions related to your rights as they related to this research, please contact the ICF IRF at IRB@icf.com.

1) Do you agree to participate in this survey?
   - o YES
   - **o** NO

Section 1. Current Mental Health and Wellbeing

Thank you for agreeing to participate in the Consumer Experience Survey. We'd first like to ask you about your overall health and mental health. These questions help us learn about how the services you received may impact you, now and in the future.

1. How would you describe your overall health at this time?
   - o Excellent
   - o Very good
   - o Good
   - o Fair
   - o Poor

2. How would you describe your overall mental health at this time?
   - o Excellent
   - o Very good
   - o Good
   - o Fair
   - o Poor

PROGRAMMER: If respondent selects "Poor" to Q2, ask Q2a.

a. You described your overall mental or emotional health as poor. Are you currently in crisis?
   - o Yes
   - o No

PROGRAMMER: If respondent selects "yes" to Q2a, please show the bold text and terminate survey.

> **If you are experiencing a crisis or are considering suicide, please talk to a trusted friend, family member, or your primary behavioral health care provider so that they can help you. You can also call or text 988 to speak to a trained crisis counselor 24 hours a day, 7 days a week, or chat with a crisis counselor at any time through the 988 Lifeline Chat.**

Next, we'll ask more about experiences you may have had related to suicide. Each of these questions helps us learn more about how behavioral health services can best support people, whether you have previously experienced suicidal thoughts and behaviors or not. Please complete each of the questions below based on what you think and believe, even if those responses are different from what you think others might want you to answer.

Sometimes being asked questions about stressful life events and suicide can bring up uncomfortable thoughts and feelings. If this happens for you, please pause or stop the survey and talk to someone you trust, like a friend or healthcare provider, so that they can help you. You can also call or text 988 to speak to a trained crisis counselor, or chat with a crisis counselor at any time by clicking this link: 988 Lifeline Chat. It's okay to pause the survey, skip questions, or stop the survey at any time.

3. Please select the option below that best reflects how you've been feeling **in the past month**. **(PROGRAMMER: This item should be asked at follow-up only)**

   a. Have you wished you were dead or wished you could go to sleep and not wake up?

      o Yes

      o No

   b. Have you actually had any thoughts of killing yourself? **(PROGRAMMER: If 'No' is selected, skip to Q4)**

      o Yes
      o No

   c. Have you thought about how you might do this?

      o Yes
      o No

   d. Have you had any intention of acting on these thoughts of killing yourself, as opposed to having the thoughts but you would definitely not act on them?

      o Yes
      o No

   e. Have you started to work out, or actually worked out, the specific details of how to kill yourself and did you actually intend to carry out the details of your plan?

      o Yes
      o No

4. **[FOLLOW-UP ONLY]** Have you **ever** done anything, started to do anything, or prepared to do anything to end your life? **(PROGRAMMER: If 'No' is selected, skip to Q5; this item should be asked at follow-up only)**

      o Yes
      o No

   a. Did this occur within the past three months?

      o Yes
      o No

5. Please review the ladder below. Each rung on this ladder represents where various individuals who have been thinking about suicide are in the process of making changes to make their lives worth living. Pick the number that indicates how you have been feeling **in the past month**.

0.	1.	2.	3.	4.	5.	6.	7.	8.
Thinking that my life is not worth living.		Think I need to start considering making changes to make my life worth living.		Think I should make changes to make my life worth living, but not quite ready.		Starting to think about how to make my life worth living.		Taking action to make my life worth living (e.g., changing substance use, enrolling in treatment).

6. Please rate each item below based on how true each of these statements is for you **in the past month**.

	Not at All True for Me	Somewhat True for me	True for Me	Very True for Me
a. The people in my life would be better off if I were gone.				
b. The people in my life would be happier without me.				
c. I think my death would be a relief to the people in my life.				
d. I think the people in my life wish they could be rid of me.				
e. I think I make things worse for the people in my life.				
f. I feel like I belong.				
g. I am lucky to have many caring and supportive friends.				
h. I feel cut off from other people.				
i. I often feel like an outsider around other people.				
j. I am close to other people.				

7. Over the **past month**, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling or staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.				
i. Thoughts that you would be better off dead, or of hurting yourself.				

	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
j. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

8. Over the **past month**, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than Half the Days	Nearly Every Day
a. Feeling nervous, anxious, or on edge				
b. Not being able to stop or control worrying				
c. Worrying too much about different things				
d. Trouble relaxing				
e. Being so restless that it is hard to sit still				
f. Becoming easily annoyed or irritable				
g. Feeling afraid, as if something awful might happen				

	Not Difficult at All	Somewhat Difficult	Very Difficult	Extremely Difficult
h. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?				

Section 2. Services Received

You were asked to complete this survey by a behavioral health provider at [ORGANIZATION NAME]. We would like for you to think back to the time when you first began seeing this provider and answer the following questions.

9. How long have you been seeing this provider?
   - o 3 months or less
   - o 3-6 months
   - o 6-12 months
   - o More than 1 year

10. Thinking back, approximately how long was it before you could get in to see this provider the first time? Please select the timeframe that is closest to the time it took to receive your first appointment. **(PROGRAMMER: This item should be asked at baseline only)**
    - o I was seen immediately
    - o Within a day
    - o Within 2 days
    - o Within a week
    - o Longer than 1 week
    - o Longer than 2 weeks
    - o Longer than a month
    - o I am not sure

11. To the best of your knowledge, has your provider ever conducted an assessment to determine your risk for suicide? This could have been done through a form you completed or questions that your provider asked you.
    - o Yes, including at my first appointment
    - o Yes, but not during the first appointment
    - o No
    - o I am not sure

PROGRAMMER: If respondent selects "yes" to Q11, proceed to Q11a.
If respondent selects "no" or "I am not sure", proceed to Q12.

a. What topics do you remember discussing? Select all that apply.
   - ☐ If I was experiencing suicidal thoughts or plans

- ☐ If I could refrain from attempting suicide
- ☐ My history of suicide attempts
- ☐ My family history
- ☐ If I had access to means for attempting suicide
- ☐ If I was misusing substances
- ☐ My reasons for living
- ☐ Other, please specify: _____

- ☐ None of these
- ☐ I am not sure

b. How often has your provider assessed your risk for suicide?

- o Once
- o It varies, but more than once
- o At every visit

- o I am not sure

12. Has your provider done any of the following as part of your care? Select all that apply.

- ☐ Call or meet with your family to discuss your care or needs
- ☐ Discuss safety in the home with your family (e.g., removing means of suicide, such as firearms)
- ☐ Discuss alternative ways of coping with distress, or alternatives to suicide with you
- ☐ Discuss your reasons for living
- ☐ Help you identify individuals you can contact if feeling suicidal
- ☐ Refer you to the emergency department or crisis service
- ☐ Provide an after-hours emergency contact number to you
- ☐ Provide an after-hours emergency contact number to your family
- ☐ Provide you with the national suicide hotline or other crisis hotline phone information
- ☐ Follow-up to see if you kept any scheduled appointments
- ☐ None of the above
- ☐ I am not sure

13. Did you and your provider develop a safety plan for you to use if you felt suicidal?

- o Yes
- o No
- o I am not sure

PROGRAMMER: If respondent selects "yes" to Q13, proceed to Q13a-c.
If respondent selects "no" or "I am not sure," skip to Q14.

a. If yes, does your safety plan include any of the following? Select all that apply.

- ☐ Warning signs that may lead you to feeling suicidal
- ☐ Coping strategies to help you feel calm and comforted
- ☐ A list of your reasons for living
- ☐ People you can talk to when feeling suicidal
- ☐ Professionals you can talk to when feeling suicidal, including hotlines

- ☐ A plan to make your environment safe, including removing or securing items you might use to hurt yourself
- ☐ Other, please specify: _____
- ☐ None of the above

- ☐ I am not sure

b. How often has your provider reviewed your safety plan with you?

- o Once, at the time it was created
- o It varies, but more than once

- o At every visit
- o I am not sure

c. Has your provider ever updated your safety plan with you?

- o Yes
- o No, but it is relatively new

- o No, but nothing has changed
- o No
- o I am not sure

14. To the best of your knowledge, have you participated in any suicide-specific treatment services with [ORGANIZATION NAME] OR through a referral/recommendation that they provided?

- o Yes
- o No **[PROGRAMMER: Skip to Q15 if this option is selected]**
- o I am not sure **[PROGRAMMER: Skip to Q15 if this option is selected]**

a. Which suicide-specific treatment services have you participated in? Select all that apply.

- ☐ Group therapy specific to suicide **[PROGRAMMER: Display Q14c if selected]**
- ☐ Individual therapy specific to suicide **[PROGRAMMER: Display Q14b if selected]**
- ☐ Suicide attempt survivor support groups
- ☐ Other care specific to suicide risk, please specify: _____
- ☐ I am not sure
- ☐ None of the above

- ☐ I am not sure

b. Which individual therapy specific to suicide have you participated in?

- ☐ Cognitive Behavioral Therapy (CBT) for Suicide Prevention
- ☐ All other CBT
- ☐ Collaborative Assessment and Management of Suicidality (CAMS)
- ☐ Dialectical Behavior Therapy (DBT)
- ☐ Other, please specify:_____

c. Which group therapy specific to suicide have you participated in?

- ☐ Dialectical Behavior Therapy (DBT)

☐ Other, please specify:_____

15. Has your provider or staff from [ORGANIZATION NAME] done any of the following **when you missed an appointment unexpectedly**? Please select all that apply.
    - ☐ Sent texts to check on you
    - ☐ Sent texts of support or encouragement
    - ☐ Sent postcards or letters
    - ☐ Sent electronic reminders of appointments (e.g., text, e-mail, app notification)
    - ☐ Followed up by phone within 24 hours
    - ☐ Followed up by phone within 48 hours
    - ☐ Followed up by phone within 1 week
    - ☐ Followed up by phone more than 1 week later
    - ☐ Send a mobile crisis team to do a well check if you did not answer calls/texts
    - ☐ Help coordinate your care with other community providers
    - ☐ Provided information on peer supports
    - ☐ Provided information on peer-run crisis respite
    - ☐ Conducted a home visit
    - ☐ Allowed drop-in appointments
    - ☐ None of the above
    - ☐ Other, please specify: _____
    - ☐ I am not sure
    - ☐ I have never missed an appointment unexpectedly

16. Have any of the following posed challenges to your ability to receive services from [ORGANIZATION NAME]? *Please select all that apply.*
    - ☐ It would cost too much
    - ☐ I do not have health insurance coverage for this kind of care
    - ☐ My health insurance would not pay enough of the costs
    - ☐ I had problems with things like transportation, childcare, or getting appointments at time that worked for me
    - ☐ I was worried that my information would not be kept private
    - ☐ I was worried about what people would think or say if I got treatment
    - ☐ I was afraid of being committed to a hospital or forced into care against my will
    - ☐ I thought I would be told I needed to take medication
    - ☐ I didn't think care would help me
    - ☐ Other: please describe _____
    - ☐ None of the above

17. In the last 12 months **[alternate wording at follow-up: in the last 6 months]**, have you experienced any of the following crisis situations? *Please select all that apply.*
    - ☐ I visited/was taken to the emergency department for a mental health or emotional problem
    - ☐ I was placed on a 72-hour psychiatric hold
    - ☐ I was hospitalized for my mental health
    - ☐ I received care through a residential treatment program (non-inpatient setting)
    - ☐ I received care through a day treatment program

☐ I was hospitalized in a facility for detox/inpatient treatment for substance use
☐ I visited/was taken to the emergency department for a substance use problem
☐ I accidentally overdosed on opioids

☐ I accidentally overdosed on another type of drug
☐ Other, please describe _____
☐ I have not experienced any of these situations

PROGRAMMER:

- **If respondent selects "I accidentally overdosed on opioids" or "I accidentally overdosed on another type of drug," proceed to Q17a.**
- **If respondent selects any other type of crisis event (other than an overdose), skip to Q17b.**
- **If respondent selects "I have not experienced any of these situations", proceed to section 3.**

a. You indicated that you overdosed on opioids or another type of drug within the last 12 **[alternate at follow-up: 6]** months. Did you receive medical treatment or other intervention related to this overdose?

o Yes
o No
o I am not sure

b. Around the time of this crisis event, were you receiving services at [ORGANIZATION NAME]?

o Yes, I was already receiving services before the crisis
o Yes, I started receiving services immediately after or because of the crisis (within 2-3 weeks after discharge)
o No, I was not receiving services before or immediately after the crisis
o I am not sure

c. Approximately how long was it before you got in to see a provider at [ORGANIZATION NAME] the first time after this crisis event? Please select the timeframe that is closest to the time it took to receive your appointment.

o I was seen immediately
o Within 24 hours
o Within 48 hours
o Within 1 week
o Longer than 1 week
o Longer than 2 weeks
o Longer than a month

o I am not sure

d. In the period shortly after this crisis event, did your provider or staff from [ORGANIZATION NAME] do any of the following? Select all that apply.

☐ Sent texts to check on you
☐ Sent texts of support or encouragement

- ☐ Sent postcards or letters
- ☐ Sent electronic reminders of appointments (e.g., text, e-mail, app notification)
- ☐ Followed up by phone within 24 hours
- ☐ Followed up by phone within 48 hours
- ☐ Followed up by phone within 1 week
- ☐ Followed up by phone more than 1 week later
- ☐ Send a mobile crisis team to do a well check if you did not answer calls/texts
- ☐ Help coordinate your care with other community providers
- ☐ Provided information on peer supports
- ☐ Provided information on peer-run crisis respite
- ☐ Conducted a home visit
- ☐ Allowed drop-in appointments
- ☐ None of the above
- ☐ Other, please specify: _____
- ☐ I am not sure

Section 3. Perceptions and Satisfaction

In this section, we would like to know your perceptions of and level of satisfaction with the services you've received from your therapist or other primary behavioral health provider at [ORGANIZATION NAME].

18. Please respond to each of the questions below based on how you feel about the services you receive from [ORGANIZATION NAME] related to your suicide or crisis risk. As you answer these questions, think about the behavioral health provider you see most often and that is most involved with this care.

	Never	Sometimes	Fairly Often	Very Often	Always
a. As a result of these services, I am clearer as to how I might be able to change.					
b. What I am doing gives me new ways of looking at my problem.					
c. I believe my primary provider likes me.					
d. My primary provider and I collaborate on setting goals for my services/care.					
e. My primary provider and I respect each other.					
f. My primary provider and I are working towards mutually agreed upon goals.					
g. I feel that my primary provider appreciates me.					
h. My primary provider and I agree on what is important for me to work on.					DB
i. I feel my primary provider cares about me even when I do things that they do					

	Never	Sometimes	Fairly Often	Very Often	Always
not approve of.					
j. I feel that the things I do in my services/care will help me accomplish the changes that I want.					
k. My primary provider and I have established a good understanding of the kind of changes that would be good for me.					
l. I believe the way that we are working with my problem is correct.					

19. Think about the parts of your culture that are important to your identity, or who you are as a person. This can include things like race or ethnicity, gender, age, disability status, sexual orientation, and many other factors. Please select the option that best describes how much you agree or disagree with with each statement about your primary behavioral health provider at [ORGANIZATION NAME].

When important parts of my culture come up or are discussed, my primary behavioral health provider…

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
a. …appears guarded.					
b. …changes the subject to another topic.					
c. …stumbled with words.					
d. …seems unsure about how to behave.					
e. …appears anxious.					
f. …seems annoyed.					
g. …becomes defensive.					
h. …seems angry.					
i. …seems comfortable in our interaction.					
j. …has a relaxed demeanor.					
k. …seems at ease with me.					
l. …seems genuine.					
m. …seems comfortable talking with me.					

20. Next, we'd like to know more about what you think about the care or services you receive at [ORGANIZATION NAME]. Using the provided rating scale, please answer the questions below based on your experiences with your current care at this organization.

	Strongly	Disagree	Neutral	Agree	Strongly

	Disagree				Agree
a. I will be able to complete these services.					
b. I will be able to follow the requirements of my services.					
c. I find my services exhausting.					
d. I feel uncomfortable when I participate in these services.					
e. Overall, I find these services intrusive.					
f. These services will provide effective ways to help me cope with mental health.					
g. I would prefer to try another type of service, instead of the ones I'm currently receiving.					
h. I would prefer to receive medication for mental health instead of these services.					
i. I would recommend these services to a friend with a similar problem.					
j. I will likely drop out of these services.					

21. What has been the most helpful part of the care you have received to address your suicide or crisis risk? **[PROGRAMMER: THIS IS AN OPEN-TEXT QUESTION]**

22. If you could make one recommendation to improve care related to suicide or crisis risk, what would you suggest? **[PROGRAMMER: THIS IS AN OPEN-TEXT QUESTION]**

Section 4. About You

Finally, we'd like to hear about you. Please tell us about yourself.

23. Have you ever been in the United States Armed Forces, or another military?

    a. Are you currently on active duty in the United States Armed Forces, are you in a Reserve component, or are you now separated or retired from the military?
        - o On Active Duty in the Armed Forces **[PROGRAMMER: Skip to Q23c if selected]**
        - o In a Reserve Component **[PROGRAMMER: Continue to Q23b if selected]**
        - o Now Separated or Retired from the Military **[PROGRAMMER: Continue to Q23b if selected]**
        - o Prefer not to answer **[PROGRAMMER: Continue to Q23b if selected]**

    b. Have you ever served on active duty in the United States Armed Forces or Reserve components? Active duty does not include training for the Reserves or National Guard, but does include activation, for example, for a national emergency or military conflict
        - o Yes **[PROGRAMMER: Continue to Q23c if selected]**
        - o No **[PROGRAMMER: Skip to Q24 if selected]**
        - o Prefer not to answer **[PROGRAMMER: Skip to Q24 if selected]**

    c. Did you ever serve on active duty in the United States Armed Forces or Reserve components in a military combat zone or an area where you drew imminent danger pay or hostile fire pay?
        - o Yes
        - o No
        - o Prefer not to answer

24. Is anyone in your family or someone close to you currently serving on active duty or retired/separated from the Armed Forces, a Reserve component, or the National Guard?
    - o Yes, only one person
    - o Yes, more than one person
    - o No
    - o Prefer not to answer

25. In the past 30 days, where have you been living most of the time?
    - o Private residence
    - o Foster home
    - o Residential care
    - o Crisis residence
    - o Residential treatment center

- o Institutional setting
- o Jail/correctional facility
- o Homeless/shelter
- o Other, please specify: _____
- o Prefer not to answer

26. In the past 30 days, have you been satisfied with the conditions of your living space?
    - o Yes
    - o No
    - o Prefer not to answer

27. How old are you? ____ years
    - o Prefer not to answer

28. What is your race and/or ethnicity? Select all that apply and enter additional details in the spaces below.
    - ☐ **American Indian or Alaska Native -** Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.
      [PROGRAMMER: This is an open-text response option]
    - ☐ **Asian –** Provide details below.
        - ☐ Chinese
        - ☐ Vietnamese
        - ☐ Asian Indian
        - ☐ Korean
        - ☐ Filipino
        - ☐ Japanese
        - ☐ Enter, for example, Pakistani, Hmong, Afghan, etc.
          [PROGRAMMER: This is an open-text response option]
    - ☐ **Black or African American** – Provide details below.
        - ☐ African American
        - ☐ Nigerian
        - ☐ Jamaican
        - ☐ Ethiopian
        - ☐ Haitian
        - ☐ Somali
        - ☐ Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.
          [PROGRAMMER: This is an open-text response option]
    - ☐ **Hispanic or Latino** – Provide details below.
        - ☐ Mexican
        - ☐ Cuban
        - ☐ Puerto Rican
        - ☐ Dominican
        - ☐ Salvadoran
        - ☐ Guatemalan
        - ☐ Enter, for example, Colombian, Honduran, Spaniard, etc.

[PROGRAMMER: This is an open-text response option]

- ☐ **Middle Eastern or North African** – Provide details below.
  - ☐ Lebanese
  - ☐ Syrian
  - ☐ Iranian
  - ☐ Iraqi
  - ☐ Egyptian
  - ☐ Israeli
  - ☐ Enter, for example, Moroccan, Yemeni, Kurdish, etc.
    [PROGRAMMER: This is an open-text response option]
- ☐ **Native Hawaiian or Pacific Islander** – Provide details below.
  - ☐ Native Hawaiian
  - ☐ Tongan
  - ☐ Samoan
  - ☐ Fijian
  - ☐ Chamorro
  - ☐ Marshallese
  - ☐ Enter, for example Chuukese, Palauan, Tahitian, etc.
    [PROGRAMMER: This is an open-text response option]
- ☐ **White –** Provide details below.
  - ☐ English
  - ☐ Italian
  - ☐ German
  - ☐ Polish
  - ☐ Irish
  - ☐ Scottish
  - ☐ Enter, for example, French, Swedish, Norwegian, etc.
    [PROGRAMMER: This is an open-text response option]
- o I prefer not to answer

29. Which of the following do you consider yourself to be?

- ☐ Male
- ☐ Female
- ☐ Transgender (Male to Female)
- ☐ Transgender (Female to Male)
- ☐ Non-binary
- ☐ Two Spirit [RESPONSE ONLY AVAILABLE TO THOSE THAT INDICIATE AI/AN]
- ☐ I use a different term, please specify: _____

- ☐ Prefer not to answer

30. Which of the following do you think of yourself as?

- ☐ Gay or lesbian
- ☐ Straight, that is not gay or lesbian
- ☐ Bisexual
- ☐ Two Spirit **[RESPONSE ONLY AVAILABLE TO THOSE THAT INDICIATE AI/AN]**
- ☐ I use a different term, please specify: _____

☐ Prefer not to answer

Thank you for completing this survey! Please click 'Next' below to finalize your responses. Once you have submitted your responses, you will be automatically directed to a short form that will provide information on how to get your gift card.

[PROGRAMMER: ADD FINAL DETAILS OF GIFT CARD REDEMPTION CODE, TO BE DISPLAYED ON THIS SCREEN].