

OUTPATIENT FACILITIES SUPPLEMENT

Location # _____

Address of this Facility _____

(Outpatient Visits (OPV) are determined by taking the number of clients times the number of times they visit the facility.)

Mental Health Counseling	_____ # opv's	Substance Abuse Counseling	_____ # opv's
Family Counseling	_____ # opv's	Special School	_____ average # attending daily
Referral Agency	_____ # opv's	Senior Citizen Daycare	_____ average # attending daily
Employee Assistance Program	_____ # opv's		

1. Attach brochure or provide full description of programs and services offered: _____

2. a. Number of client contacts per year: _____ (excluding Methadone Maintenance if any.)
(each client x the number of times each seen)
b. Number of Group Sessions _____ c. Number of Individual Contacts: _____
(b. and c. should equal total number indicated in question a.)
3. Does the applicant conduct a methadone maintenance program? Yes No
If Yes, number of client contacts annually: _____
4. Does the applicant operate a crisis hotline? Yes No
How many calls received yearly? _____
5. Does the applicant make telephone referrals? Yes No If Yes, how many? _____
6. Are there any residential treatment facilities? Yes No If Yes, complete Residential Facility Supplement.
7. Describe all recreational facilities: _____
8. Are child care services available? Yes No If Yes, describe: _____

