Capital BlueCross
OUTPATIENT SUBSTANCE ABUSE FACILITY SURVEY – BRANCH OFFICE

Provider Name: ____________________
Person completing survey: ____________________ **Phone:** __________ **Date:** __________
Contact person (if different than above): ____________________ **Phone:** __________

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (✓).

ADMINISTRATION

Current Licenses

OP Substance Abuse ☐ Yes ☐ No
Partial Substance Abuse ☐ Yes ☐ No
Other: ____________________

Hours of Operation: ____________________
Program Capacity: __________
Average number of treatment sessions: __________
Average number of clients in group: __________
Most Frequent Diagnosis: ____________________
Handicap accessible ☐ Yes ☐ No
Emergency supplies available ☐ Yes ☐ No
Written transfer agreement to acute care ☐ Yes ☐ No
If **yes**, list facilities: ____________________

Access to 911 ☐ Yes ☐ No
Corporate policy and procedure manual on-site ☐ Yes ☐ No
Services for hearing impaired ☐ Yes ☐ No
Services for speech impaired ☐ Yes ☐ No
Services for visually impaired ☐ Yes ☐ No
Bilingual services ☐ Yes ☐ No
Bilingual patient education materials ☐ Yes ☐ No
Languages offered: ____________________

QUALITY MANAGEMENT

Quality Activities

Site incorporated into parent Performance Improvement program ☐ Yes ☐ No
If **no**, does site maintain separate PI Program ☐ Yes ☐ No

Clinical Management

Time frame for scheduling initial appointment: __________

STAFF

Parent Corporation responsible for staff credentialing (verification of licensure and education): ☐ Yes ☐ No
If **no**, site maintains written policy for credentialing the following staff:
Physicians ☐ Yes ☐ No
Nursing ☐ Yes ☐ No
Allied Health ☐ Yes ☐ No

Staff shared between sites ☐ Yes ☐ No
If **yes**, describe: ____________________

If **no**, complete the following:
__________ # of RNs
__________ # of CACs
__________ # of Licensed Psychologists
__________ # of Bachelor prepared Counselors
__________ # of Master prepared Counselors
__________ # of Counselor Assistants
List other clinical employees:
____

Provider Name:

Minimum of 1 CPR certified staff present at all times ☐ Yes ☐ No

SERVICES

Services provided to:

Children ☐ Yes ☐ No
Adolescents ☐ Yes ☐ No
Adults ☐ Yes ☐ No
Other: ____________

Therapies offered:

Individual ☐ Yes ☐ No
Group ☐ Yes ☐ No
Family ☐ Yes ☐ No
Couples ☐ Yes ☐ No

Other: ____________

FACILITY / SAFETY

Written emergency preparedness plan ☐ Yes ☐ No

Plan includes procedures for the following:

Fire ☐ Yes ☐ No
Loss of utilities ☐ Yes ☐ No
Inclement weather ☐ Yes ☐ No

Number of fire extinguishers: ____________
Number of fire drills per year: ____________
Fire extinguishers checked annually ☐ Yes ☐ No
Fire evacuation plan posted within facility ☐ Yes ☐ No

COMMENTS

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Provider Name:

Adams ❑	____________	Lehigh ❑	____________
Berks ❑	____________	Mifflin ❑	____________
Centre ❑	____________	Montour ❑	____________
Columbia ❑	____________	Northampton ❑	____________
Cumberland ❑	____________	Northumberland ❑	____________
Dauphin ❑	____________	Perry ❑	____________
Franklin ❑	____________	Schuylkill ❑	____________
Fulton ❑	____________	Snyder ❑	____________
Juniata ❑	____________	Union ❑	____________
Lancaster ❑	____________	York ❑	____________
Lebanon ❑	____________		

Other ❑ ____

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