

**ADDITIONAL FACILITY PRACTICE LOCATIONS**
**Location** \_\_\_\_\_ of \_\_\_\_\_

Location Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

**Psychiatric / Mental Health Services (Mark all services and ages that apply.)**

	Child	Adolescent	Adult	Geriatric
<input type="checkbox"/> Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Partial (PHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Substance Use Disorder / Chemical Dependency Services (Mark all services and ages that apply.)**

	Child	Adolescent	Adult	Geriatric
<input type="checkbox"/> Inpatient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Partial (PHP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> IOP	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Residential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Observation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

 Methadone services offered     Suboxone services offered

 ECT Offered     Inpatient     Outpatient

 Genders treated     Male     Female

# I/P Beds (Mental Health) \_\_\_\_\_ # I/P Beds (Substance Use) \_\_\_\_\_

**Accessibility and Hours for this Location**

 Languages Spoken     English     Spanish     Hmong     Burmese     Rohingya  
*(Check all that apply)*     Somali     Russian     Ukrainian     Arabic     Pashto  
                                   Hindi     German     Polish     Italian     French  
                                   Swahili     Yiddish     Vietnamese     Korean     Laotian  
                                   Chinese Mandarin     Other \_\_\_\_\_

 Wheelchair accessible

 Open at least 5 days per week

**Daily Hours (Check all the days that apply and add daily hours of operation.)**

	Time Open	a.m.	Time Close	p.m.		Time Open	a.m.	Time Close	p.m.
<input type="checkbox"/> Monday	_____		_____		<input type="checkbox"/> Friday	_____		_____	
<input type="checkbox"/> Tuesday	_____		_____		<input type="checkbox"/> Saturday	_____		_____	
<input type="checkbox"/> Wednesday	_____		_____		<input type="checkbox"/> Sunday	_____		_____	
<input type="checkbox"/> Thursday	_____		_____						

*Please complete this form for each of your locations, if applicable, and submit with your application.*