Behavioral Health Advisory Board Site Visit Report Date: Facility / Program: Location: Phone #: _____ E-mail: ____ Contact Person: **BHAB Review Team:** FACILITY / PROGRAM DEMOGRAPHICS 1. Age Group Served: (Check all that apply) Children (0 - 12) Adolescents (13 - 17) TAY (18 - 25) Adults (18 - 61) Older Adults (60 +) 2. Number of Clients Served: Maximum possible: Monthly Avg. and / or Daily Avg. 3. Services Provided: (i.e.: Counseling, Therapy, Medication management, Nursing, etc.)? 4. Miscellaneous Additional Services: (i.e.: transportation, follow-up care, community activities or support, etc.)? 5. Number of on-site staff having direct client contact: 6. What kind of training does your organization provide the staff, and how often? 7. Which professionals are involved directly with clients (i.e. Psychiatrist, Psychologist, MFT, ADT, LCSW, Nurse) and how often? 8. Are peer support specialists/individuals in recovery utilized to support your clients? How many and how often? Are family members involved? How? 9. Describe Groups - education/support? 10. Facility/Program Physical Layout (i.e. indoor rooms, outdoor areas, recreational areas)? (Attach floor plan if available)

BHAB Reviewer Response	***************************************
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