

SAMHSA INVENTORY OF SUBSTANCE ABUSE TREATMENT SERVICES (I-SATS) NEW SUBSTANCE ABUSE FACILITY REGISTRATION REQUEST

[Instructions and Definitions](#) / [Questions and Comments](#)

I-SATS ID : (Assigned by I-SATS Database manager)

Activation Date: (MM/DD/YYYY)

REQUIRED NEW FACILITY INFORMATION	
Facility Status: <input checked="" type="radio"/> State Approved Facility <input type="radio"/> Non-State Approved Facility	
Facility Name	
1.	<input type="text"/>
2.	<input type="text"/>
Location Address	
1.	<input type="text"/>
2.	<input type="text"/>
City, State, Zip Code (Location)	
<input type="text"/>	, AL <input type="text"/> - <input type="text"/>
County Name	
<input type="text"/>	
Mailing Address (if different)	
1.	<input type="text"/>
2.	<input type="text"/>
<input type="text"/>	, <input type="text"/> - <input type="text"/>
Telephone Number: (<input type="text"/>) <input type="text"/> - <input type="text"/> ext: <input type="text"/>	
Fax Number: (<input type="text"/>) <input type="text"/> - <input type="text"/> None: <input checked="" type="checkbox"/>	
TEDS Reporter: <input type="radio"/> Yes <input type="radio"/> No <input checked="" type="radio"/> Don't know	
Services Provided:	
<input type="radio"/> Administrative Services ONLY	
<input type="radio"/> Substance Abuse Treatment/Detoxification	
<input type="radio"/> Non-Treatment Halfway House	
<input checked="" type="radio"/> Other Non-treatment Services Only	
All fields below this point are optional	
STATE ID	
<input type="text"/>	
FDA (Methadone) ID	
<input type="text"/>	
EIN	
<input type="text"/>	
Director Name, Title	
Prefix: <input type="text"/>	

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First:	<input type="text"/>
MI:	<input type="text"/>
Last:	<input type="text"/>
Suffix:	<input type="text"/>
Title:	<input type="text"/>
Director Phone Number / Ext.	
	(<input type="text"/>) <input type="text"/> - <input type="text"/> ext: <input type="text"/>

SAMHSA INVENTORY OF SUBSTANCE ABUSE TREATMENT SERVICES (I-SATS) SUBSTANCE ABUSE FACILITY CHANGE REQUEST

[Instructions and Definitions](#) / [Questions and Comments](#)

I-SATS ID : VA902757

Reason for Close/Change:

1)

2)

Effective Date of Change or Date Facility Closed: (MM/DD/YYYY)

CURRENT FACILITY INFORMATION	UPDATED FACILITY INFORMATION
REQUIRED FACILITY INFORMATION	
Status Code: I Status Date: 13-SEP-01	Status Code: <input type="radio"/> Active <input checked="" type="radio"/> Inactive/Closed
Facility Status: State Approved Facility	Facility Status: <input checked="" type="radio"/> State Approved Facility <input type="radio"/> Non-State Approved Facility
STATE ID VA902757	STATE ID <input type="text" value="VA902757"/>
Facility Name Primavera Treatment Center	Facility Name 1. <input type="text" value="Primavera Treatment Center"/> 2. <input type="text"/>
Location Address 1111 North 19th Street Suite 201 City, State, Zip Code (Location) Arlington, VA 22209	Location Address 1. <input type="text" value="1111 North 19th Street"/> 2. <input type="text" value="Suite 201"/> City, State, Zip Code <input type="text" value="Arlington"/> , <input type="text" value="VA"/> <input type="text" value="22209"/> - <input type="text"/>
County Name: Arlington	County Name: <input type="text" value="Arlington"/>
Mailing Address (if different)	Mailing Address (if different) 1. <input type="text"/> 2. <input type="text"/> <input type="text"/> , <input type="text"/> <input type="text"/> - <input type="text"/>
Telephone Number / Ext. (703)276-1811 Ext.	Telephone Number / Ext. (<input type="text" value="703"/>) <input type="text" value="276"/> - <input type="text" value="1811"/> ext: <input type="text"/>
Fax Number	Fax Number (<input type="text"/>) <input type="text"/> - <input type="text"/> None: <input checked="" type="checkbox"/>
TEDS Reporter: N	TEDS Reporter: <input type="radio"/> Yes <input checked="" type="radio"/> No <input type="radio"/> Don't Know
Services Provided: Substance Abuse Treatment/Detoxification	Services Provided: <input type="radio"/> Administrative Services ONLY <input checked="" type="radio"/> Substance Abuse Treatment/Detoxification <input type="radio"/> Non-Treatment Halfway House <input type="radio"/> Other Non-treatment Services Only

All fields below this point are optional

FDA (Methadone) ID:	FDA (Methadone) ID: <input type="text"/>
EIN:	EIN: <input type="text"/>
Director Name and Title	Director Name Prefix: <input type="text"/> First: <input type="text"/> MI: <input type="text"/> Last: <input type="text"/> Suffix: <input type="text"/> Title: <input type="text"/>
Director Phone Number / Ext.	Director Phone Number / Ext. (<input type="text"/>) <input type="text"/> - <input type="text"/> ext: <input type="text"/>