EXHIBIT 131

COMMUNITY MENTAL HEALTH CENTER CRUCIAL DATA EXTRACT

_____	_____	_____
Provider No.	Facility Name/Address	Date

Telephone No: (_____)_____

Is this part of a Medicare/ Medicaid Provider? _____Yes _____No

If "Yes" indicate either: A. Hospital Provider No. _____

B. Home Health Agency Provider No. _____

C. Other Provider No. _____

Type of Ownership or Control: Enter number: _____

_____(01) Proprietary _____(05) State

_____(02) Church related _____(06) Local

_____(03) Nonprofit Corp. _____(07) Federal

_____(04) Other nonprofit

Enter number of full time equivalents (FTEs) providing services below:

	Directly	**Under Arrangement/Contract**
M.D. (Psychiatrist)	_____	_____
M.D. (Other)	_____	_____
Psychologist	_____	_____
Nurse	_____	_____
Social Worker (B.S.W.)	_____	_____
Social Worker (M.S.W.)	_____	_____
Therapist (Recreational)	_____	_____
Therapist (Occupational)	_____	_____
Therapist (Group)	_____	_____
Other (Specify)	_____	_____
Total Services:	_____	_____

The following data are to be completed by the State Agency:

_____ State/County Code: _____ _ _ _ _ _

State/Region Code:____