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| logoRGB | **SUD Consumer Satisfaction Survey FY2020** |
| In order to provide the best services, we would like to know what you think about the services you have received from <**INSERT CMHSP or SUD PROVIDER NAME>** during the last **twelve** months, the people who provided these services to you, and the results that have been achieved. There are no right or wrong answers to the questions in this survey. The results will be used for quality improvement efforts.  **[CMHSP or Provider Agency Name]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_**   |  | | --- | | **Please answer the following by checking the appropriate box.**  **I am:**  **Female**  **Male**  **My age group is:**  **0 – 17**  **18 – 30**  **31 – 40**  **41 – 50**  **51 – 60**  **61+**  **The type of treatment I receive is:**  **Outpatient**  **Intensive Outpatient**  **Detox**  **Residential**  **Methadone / MAT**  **Co-occurring**  **Case Management**  **Early Intervention** |   Please indicate your agreement or disagreement with each of the following statements by checking the appropriate box that best represents your opinion. If a question does not apply to you, then mark the “NA” box for “not applicable.”  When indicating your responses, consider “strongly agree” to mean, “I would not make major changes to <**INSERT CMHSP or SUD PROVIDER NAME>** on the issue in question” and “strongly disagree” to mean, “I would recommend major changes to **<INSERT CMHSP or SUD PROVIDER NAME>** based on the issue in question.”  Your answers will remain strictly confidential   |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | | **Welcoming Environment** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. Staff was courteous and respectful. |  |  |  |  |  |  | | 1. I would recommend this agency to others. |  |  |  |  |  |  | | **Information on Recipient Rights** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. I was informed of my rights. |  |  |  |  |  |  | | 1. I know how to contact my recipient rights advisor. |  |  |  |  |  |  | | 1. I was informed that information about my treatment is only given with my permission. |  |  |  |  |  |  | | **Cultural/Ethnic Background** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. My cultural/ethnic background was respected. |  |  |  |  |  |  | | **Appropriateness and Choice with Services** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. I was given information about the different treatment options available that would be appropriate to meet my needs. |  |  |  |  |  |  | | 1. I received services that met my needs and addressed my goals. |  |  |  |  |  |  | | 1. I was given a choice as to what provider to seek treatment from. |  |  |  |  |  |  | | **Treatment Planning/Progress Towards Goals** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. I was involved in the development of my treatment plan and goals. |  |  |  |  |  |  | | 1. My goals were addressed during treatment. |  |  |  |  |  |  | | 1. My goals were changed when needed to reflect my needs. |  |  |  |  |  |  | | 1. I feel that I am better able to control my life as a result of treatment. |  |  |  |  |  |  | | **Coordination of Care/Referrals to Other Resources** | **Strongly Agree**  **(SA)** | **Agree**  **( A )** | **I am Neutral**  **( N )** | **Disagree**  **( D )** | **Strongly Disagree (SD)** | **Not Applicable (NA)** | | 1. Staff assisted in connecting me with further services and/or community resources. |  |  |  |  |  |  | | 1. My treatment plan includes skills and community supports to help me continue in my path to recovery and total wellness. |  |  |  |  |  |  | | |

**Comments (optional):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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If you would like someone from **<INSERT CMHSP or SUD PROVIDER NAME>** to work with you on addressing any concerns you may have noted above, please provide us with your name and contact information.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Or you may contact the <**INSERT CMHSP or SUD PROVIDER NAME>** directly at:

**<INSERT CONTACT INFORMATION/PHONE NUMBER>**

**Thank you for completing this survey.**