

Background Information (continued)

17. In the past 12 months, have you been involved in a self-help or peer support group in any way?  
 Yes     No     I do not know what a self-help or peer support group is
18. Who helped you with taking this survey (e.g. collected it from you, helped you with questions or reading etc.)?  
 A consumer peer     Peer     Other Staff member     No one
19. How long have you received mental health services from this program?  
 Less than one year     One year or more
20. How often do you receive services from this program?  
 2-5 days per week     1 time per week     1-2 times per month     Less than 1 time per month

21. What were the 2 most **helpful** services provided by this program?

1) \_\_\_\_\_  
 \_\_\_\_\_  
 2) \_\_\_\_\_  
 \_\_\_\_\_

22. What 2 things would you **change** about services provided by this program?

1) \_\_\_\_\_  
 \_\_\_\_\_  
 2) \_\_\_\_\_  
 \_\_\_\_\_

Affix Label Here

<p><b>Facility</b> _____</p> <p><b>Site Name</b> _____</p>
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Thank you for completing this survey!



Consumer Assessment of Care Survey 2015

We want to provide the best possible mental health services in our program. To do so, we need to know what you think about the services you received during the last 3 months, the people who provided the services, and the results. Please check the back page to make sure our agency and site names are filled-in. On that page, you will also see space to comment on any of your answers.

Please indicate your agreement / disagreement with each of the following statements by shading the circle that best represents your opinion. If the question is about something you have not experienced, shade the circle to indicate that this item is "not applicable" to you.

Shade Circles Like This--> ●  
 Not Like This--> ⊗ ⊙

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
1. I like the services that I received here.....	<input type="radio"/>					
2. If I had other choices, I would still get services from this agency.....	<input type="radio"/>					
3. I would recommend this agency to a friend or a family member.....	<input type="radio"/>					
4. The location of services was convenient (parking,public transportation distance,etc.).....	<input type="radio"/>					
5. Staff were willing to see me as often as I felt it was necessary.....	<input type="radio"/>					
6. Staff returned my call in 24 hours.....	<input type="radio"/>					
7. Services were available at times that were good for me.....	<input type="radio"/>					
8. I was able to get all the services I thought I needed.....	<input type="radio"/>					
9. I was able to see a psychiatrist when I wanted to.....	<input type="radio"/>					
10. Staff here believe that I can grow, change and recover.....	<input type="radio"/>					
11. I felt comfortable asking questions about my treatment and medication.....	<input type="radio"/>					
12. I felt free to complain.....	<input type="radio"/>					
13. I was given information about my rights.....	<input type="radio"/>					
14. Staff encouraged me to take responsibility for how I live my life.....	<input type="radio"/>					
15. Staff told me what side effects to watch out for.....	<input type="radio"/>					
16. Staff respected my wishes about who is and who is not to be given information about my treatment.....	<input type="radio"/>					
17. I, not staff, decided my treatment goals.....	<input type="radio"/>					
18. Staff were sensitive to my cultural background (race, religion, language, etc.).....	<input type="radio"/>					
19. Staff helped me obtain the information I needed so that I could take charge of managing my illness.....	<input type="radio"/>					
20. I was encouraged to use consumer-run programs (support groups, drop-in centers,crisis phone line, etc).....	<input type="radio"/>					



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In order to provide the best possible mental health services, we need to know what you think about the services you received during the last 3 months, the people who provided them, and the results. There is space at the end of the survey to comment on any of your answers.

Shade Circles Like This--> ●  
 Not Like This--> ⊗

As a Direct Result of Services I received :

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
21. I deal more effectively with daily problems.....	<input type="radio"/>					
22. I am better able to control my life.....	<input type="radio"/>					
23. I am better able to deal with crises.....	<input type="radio"/>					
24. I am getting along better with my family.....	<input type="radio"/>					
25. I do better in social situations.....	<input type="radio"/>					
26. I do better in school and/or work.....	<input type="radio"/>					
27. My housing situation has improved.....	<input type="radio"/>					
28. My symptoms are not bothering me as much.....	<input type="radio"/>					
29. I do things that are more meaningful to me.....	<input type="radio"/>					
30. I am better able to take care of my needs.....	<input type="radio"/>					
31. I am better able to handle things when they go wrong.....	<input type="radio"/>					
32. I am better able to do things that I want to do.....	<input type="radio"/>					

For questions 33-36 please answer for relationships with persons other than your mental health provider(s)

33. I am happy with the friendships I have.....	<input type="radio"/>					
34. I have people with whom I can do enjoyable things.....	<input type="radio"/>					
35. I feel I belong in my community.....	<input type="radio"/>					
36. In a crisis, I would have the support I need from family or friends.....	<input type="radio"/>					

In the section, we ask you to rate how things are going in different areas of your life. Please read the statement and then fill in the circle that best represents your experiences. How would you rate the following ?

	Strongly Agree	Agree	I am Neutral	Disagree	Strongly Disagree	Not Applicable
37. I generally have enough money to buy what I need.....	<input type="radio"/>					
38. I have access to transportation to get around.....	<input type="radio"/>					
39. I am generally able to have fun and relax.....	<input type="radio"/>					
40. My physical health is excellent.....	<input type="radio"/>					
41. My self-respect (how I feel about myself) is positive.....	<input type="radio"/>					
42. Overall, things in my life are going well.....	<input type="radio"/>					

Background Information

Please provide the following information for statistical purposes. Please do not share your name. This confidential information is very important to help ensure that services meet your needs. Please fill in the blanks or shade in the circles that answers the following.

- Which of the following insurance plans are you covered by? (*shade all circles that apply*)  
 Medicare     Medicaid     HMO     PMHP     Other \_\_\_\_\_     Don't Know
- What county do you live in (e.g. Erie, Suffolk, etc.)? \_\_\_\_\_
- Are you of Hispanic/Latino Origin?     Yes, Hispanic or Latino     Not Hispanic or Latino
- What is your race? (*shade one or more circles to indicate what you consider your race to be*)  
 White (Caucasian)     Black/African American     American Indian /Alaskan Native  
 Native Hawaiian / Pacific Islander     Asian     Other \_\_\_\_\_
- What is your primary language?  
 English     Spanish     Other \_\_\_\_\_
- What is your sex?     Male     Female
- What is your age?     18-24     25-34     35-44     45-54     55-64     65-74     75 +
- Have you had a comprehensive physical examination (at a health clinic or with a family doctor) in the past 12 months?  
 Yes     No
- How many days during the last month (30 days) was your physical health not good?   (enter number of days in box)
- When was the last time you smoked tobacco or used tobacco products?  
 Today     Sometime in the past week     Sometime in the past month     1-12 months ago  
 1-5 years ago     More than 5 years ago     Never
- Which tobacco products do you currently use? (*shade all circles that apply*)  
 Cigarettes     Pipe or Cigar     Smokeless Tobacco  
 Chewed tobacco or dipped snuff     I do not use any tobacco products
- Did any staff from this program ask you if you smoke tobacco or use tobacco products?     Yes     No
- Were you asked if you wanted help to stop smoking or using tobacco products?.....     Yes     No
- Have you worked for pay in the past year? (this can be either on the books or under the table)  
 Yes     No
- Did staff from the program ever help you with pre-employment services? (for example resume writing, practice interviewing, appropriate clothing, email accounts, job search, other)  
 Yes     No
- Did staff from this program ever provide information on the following common work incentive programs: Medicaid Buy-in, IRWE, PASS plans, ticket to work, waiver of overpayment, 1619b?  
 Yes     No



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