The Client Writes®

Satisfaction Measurement For Behavioral Healthcare Providers

Overview Of The Client Writes® Survey Questionnaires

Note:
- The "X" indicates the survey item is contained on the questionnaire.
- Youth and Parent versions available on selected modules.

		THE CLIENT WRITES® QUESTIONNAIRES (Adult Versions				
		In patient	Out patient	Partial Hospital	Resid ential	Case Mgmt
I.	**BACKGROUND**					
1.	Age	X	X	X	X	X
2.	Sex	X	X	X	X	X
3.	Who referred you to our organization?	X	X	X	X	
4.	Approximately how long did you stay in our program?	X		X	X	X
5.	Please describe your length of stay in our program.	X				
6.	How long did you wait before getting "1st appointment"?		X			
7.	Approximately how many counseling visits have you had?		X			
II.	**CLIENT RATINGS**					
1	**General Ratings**					
A.	Staff concerns for confidentiality/your privacy ?	X	X	X	X	X
B.	Comfort of your room?	X			X	X
C.	Visiting hours for your family and friends?	X			X	X
D.	Courtesy and respect shown by our staff ?	X	X	X	X	X
E.	Quality of our services		X	X	X	X
F.	Rights respected by staff/information about your rights?	X	X	X	X	X
G.	Family involvement in treatment process?	X				
H.	Participation in planning your treatment?	X	X	X	X	
2	**Admitting & Financial Services**					
A.	How your admission to program was handled by staff?	X	X	X		
B.	Assistance with insurance needs?	X	X	X		
C.	Explanation given about your fees/charges ?	X	X	X		
D.	Our billing procedures?	X	X	X		
3	**Appointment Scheduling**					
A.	How long you had to wait before getting "1st appt"?		X			
B.	How efficiently your phone calls were handled?		X			
C.	Scheduling an appointment when you needed one?		X			
4	**Offices/Facility**					
A.	Location of our offices?		X	X		
B.	Appearance of our facility?		X	X		
C.	Parking for clients?		X			
D.	Privacy and comfort of counseling offices?		X	X		
E.	Hours of operation?		X			
5	**Nursing Services**					
A.	Skills and ability of nursing staff?	X				
B.	Nurses understanding of your problem/feelings?	X				
C.	Overall quality of nursing care you received on :					
	a. Day Shift (7:00 am - 3:00 pm)	X				
	b. Evening Shift (3:00 pm - 11:00 pm)	X				
	c. Night Shift (11:00 pm - 7:00 am)	X				

The Client Writes®

Satisfaction Measurement For Behavioral Healthcare Providers

Overview Of The Client Writes® Survey Questionnaires

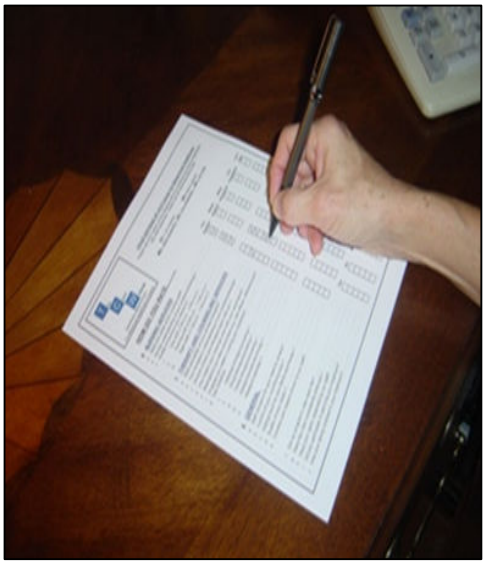
Note:
- The "X" indicates the survey item is contained on the questionnaire.
- Youth and Parent versions available on selected modules.

		THE CLIENT WRITES® QUESTIONNAIRES (Adult Versions				
		In patient	Out patient	Partial Hospital	Resid ential	Case Mgmt
6	**Therapy & Counseling**					
A.	Skills and ability of your therapist/case manager?	X	X	X	X	X
B.	Therapist/case manager understanding of problem?	X	X	X	X	X
C.	How promptly your appointments begin?	X	X	X	X	
D.	Meet with case manager when you need to?					X
E.	Helpfulness of ……..					
	a.. case manager					X
	b. nurses					X
	c. day treatment staff					X
	d. group home staff					X
F.	Medications	X	X	X	X	X
G.	Progress made in solving your problems?	X	X	X	X	X
H.	That information would be kept confidential?	X	X	X	X	X
I.	Meetings with psychiatrist?	X	X	X	X	X
J.	Services Received/Day Schedule					
	a. Group therapy/counseling	X		X	X	X
	b. Activity/recreational therapy	X		X	X	
	c. Skills training/activities of daily living			X		X
	d. Education programs					X
	e. Job coaching/training					X
	f. Transportation services					X
	g. Weekend activities?	X			X	
	h. Individual therapy/counseling?	X		X	X	X
7	**Residential Staff**					
A.	Skills and ability of residential staff?				X	
B.	Interest shown by residential staff?				X	
C.	Overall quality of services you received on :					
	a. Day Shift (7:00 am - 3:00 pm)				X	
	b. Evening Shift (3:00 pm - 11:00 pm)				X	
	c. Night Shift (11:00 pm - 7:00 am)				X	
III.	**CURRENT SITUATION**					
	How would you rate your					
1	Family relationships ?	X	X	X	X	X
2	Employment/job situation ?	X	X	X	X	X
3	Housing/living situation ?	X	X	X	X	X
4	Financial/personal money situation ?	X	X	X	X	X
5	Physical health ?	X	X	X	X	X
6	Emotional/mental health ?	X	X	X	X	X
7	Problems with alcohol or drugs ?	X	X	X	X	
9	Ability to get along with others ?	X	X	X	X	X
IV.	**SUMMARY RATINGS**					
1	Overall, how has your situation or problem(s) changed?	X	X	X	X	X
2	If a friend needed similar help, would you recommend our organization?	X	X	X	X	X
3	Overall, how satisfied are you with your experience with our organization?	X	X	X	X	X

The Client Writes®

Client Satisfaction Survey For Behavioral Healthcare Providers

Illustration of general layout and selected content of survey form



CLIENT SURVEY

Your Opinions Are Important To Us

Because your opinions are important to us, you're asked to answer the following questions. Your answers will help us learn more about the strong points of our services and where improvement may be needed. Please check the answer that best represents your opinion. We also appreciate your comments and suggestions.

I Background

1 Your age

- ☐ Less than 19 years
- ☐ 19 - 29 years
- ☐ 30 - 39 years
- ☐ 40 - 59 years
- ☐ 60 or more years

2 Your sex

- ☐ Male
- ☐ Female

3 Who referred you to

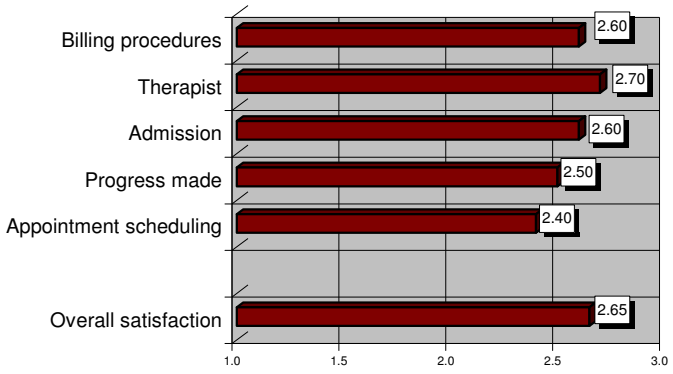
- ☐ Physician
- ☐ Family and friends
- ☐ Employer/EAP
- ☐ Court, welfare, or
- ☐ Self

II YOUR RATINGS

How do you rate ...

	Very Satisfied	Mostly Satisfied	Somewhat Dissatisfied	Very Dissatisfied	Cannot Rate
Admitting & Financial					
4. Your admission to our program	☐	☐	☐	☐	☐
5. Assistance with insurance needs	☐	☐	☐	☐	☐
6. Billing (bills understandable, timely)	☐	☐	☐	☐	☐
Appointment Scheduling					
7. Your wait to get first appointment	☐	☐	☐	☐	☐
8. Able to get appointments when needed	☐	☐	☐	☐	☐
Therapy & Counseling Services					
9. Skills and ability of your therapist	☐	☐	☐	☐	☐
10. Therapist understanding of your problems. .	☐	☐	☐	☐	☐
11. How promptly your appointments begin	☐	☐	☐	☐	☐
12. Medications your are prescribed	☐	☐	☐	☐	☐
13. Progress made in solving your problems	☐	☐	☐	☐	☐
14. Personal information kept confidential	☐	☐	☐	☐	☐

Client Perception of Care Ratings



III YOUR CURRENT SITUATION

Please tell us how your current situation has changed as a result of services you have received. If the question is about a "problem area" that does not apply to you, please check "Does Not Apply".

How to you rate your ...

	Much Better	Somewhat Better	No Change	Somewhat Worse	Much Worse	Does Not Apply
15. Family relationships . . .	☐	☐	☐	☐	☐	☐
16. Work/job situation	☐	☐	☐	☐	☐	☐
17. Housing/living situation .	☐	☐	☐	☐	☐	☐
18. Emotional/mental health .	☐	☐	☐	☐	☐	☐
19. Physical health	☐	☐	☐	☐	☐	☐
20. Alcohol/drug problems .	☐	☐	☐	☐	☐	☐
21. Financial situation	☐	☐	☐	☐	☐	☐
22. Overall, how has your situation changed? . . .	☐	☐	☐	☐	☐	☐