Form C

MHCA CUSTOMER SURVEY

Mental Health Corporations of America, Inc.

Directions

- Use a number 2 pencil or Blue or Black ink pen
- Fill in bubble completely
- Correct mark:
- Incorrect marks:

Office Use Only

Site No.	Unit	Provider	
			MH
			D&A
			Other
			IP
			OP
			P/DTP
			RS
			ES
			CM
			VS

Our organization wants to provide you and your family with the highest quality care possible. To help us evaluate and improve our services, we would like your opinion about us. The information you provide is confidential. Thinking about the service you receive, please rate the following by filling in the space on each line that best represents your opinion. If you have not experienced the specific item asked about in a question, please darken the "Not Applicable" option.

Please respond to the questions as they apply to services at: _____

	Not Applicable	Poor	Fair	Good	Very Good	Excellent
1. OVERALL						
a. Overall, how would you evaluate the quality of service you received?						
2. INTERACTION	Not Applicable	Poor	Fair	Good	Very Good	Excellent
a. Helpfulness of staff						
b. Courtesy shown to you by staff						
c. Concern of staff						
d. Attention to privacy						
e. Degree of confidentiality						
f. Professionalism of staff						
3. CLINICAL PROGRAM	Not Applicable	Poor	Fair	Good	Very Good	Excellent
a. Opportunity to participate in decisions about your treatment						
b. Extent to which your individual needs were addressed						
c. Organization of weekday program schedule						
d. Organization of weekend / holiday program schedule						
e. Appropriate therapies & interventions offered						
f. Ability of services to meet your needs						
g. Availability of staff to talk with you						
h. Ease of completing paperwork						
4. ACCESS	Not Applicable	Poor	Fair	Good	Very Good	Excellent
a. Convenience of location of facility						
b. Signs and directions to treatment areas						
c. Ability to reach desired department or person by phone						
d. Hours appointments are available						
e. Length of time between making appointment and seeing the psychiatrist						
f. Length of time between making appointment and seeing the therapist / counselor						
g. Time spent in waiting area for your scheduled appointment						
5. ENVIRONMENT	Not Applicable	Poor	Fair	Good	Very Good	Excellent
a. Safety of the environment						
b. Comfortable feeling						
c. Noise level						

Please continue on the reverse side ▶

5. ENVIRONMENT (cont)	Not Applicable	Poor	Fair	Good	Very Good	Excellent
d. Attractiveness of the facility	☐	☐	☐	☐	☐	☐
e. Cleanliness of the facility	☐	☐	☐	☐	☐	☐
f. Provision of necessary convenience items	☐	☐	☐	☐	☐	☐
g. Desirability of food	☐	☐	☐	☐	☐	☐
h. Availability of refreshments or snacks	☐	☐	☐	☐	☐	☐
6. FINANCE / BUSINESS OFFICE	**Not Applicable**	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
a. Arrangements for you to pay bill without unnecessary hardship	☐	☐	☐	☐	☐	☐
b. Reasonableness of fees	☐	☐	☐	☐	☐	☐
7. OUTCOME AND REPUTATION	**Not Applicable**	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
a. Degree to which treatment helped you deal with your problem / complaint	☐	☐	☐	☐	☐	☐
b. Willingness to return for treatment	☐	☐	☐	☐	☐	☐
c. Reputation of our organization	☐	☐	☐	☐	☐	☐
d. Overall quality of care and services	☐	☐	☐	☐	☐	☐

COMMENTS: _____

_____

The following questions are asked for the purpose of demographic or statistical information. Your responses cannot be identified.

1. Would you recommend our organization to others?

☐ Yes ☐ No

2. Have you completed treatment?

☐ Yes ☐ No

3. You came to our program with certain problems. How are those problems now?

☐ Worse
☐ Somewhat worse
☐ No change
☐ Somewhat better
☐ A great deal better

4. Age

☐ 0–5
☐ 6–12
☐ 13–17
☐ 18–44
☐ 45–64
☐ 65+

5. Are you:

☐ Male
☐ Female

6. Which best describes your ethnic background? (Mark one)

☐ White
☐ Asian
☐ Black/African American
☐ Hispanic
☐ Other

7. What was the last grade you completed in school?

☐ Less than 8th grade
☐ Some high school
☐ High school graduate
☐ Some college
☐ College graduate

8. Current marital status. (Mark one)

☐ Never married
☐ Married
☐ Divorced
☐ Widowed
☐ Separated

9. Enter today's date:

Month	Day	Year
☐ JAN	1 13 25	19 0 0
☐ FEB	2 14 26	20 1 1
☐ MAR	3 15 27	2 2
☐ APR	4 16 28	3 3
☐ MAY	5 17 29	4 4
☐ JUN	6 18 30	5 5
☐ JUL	7 19 31	6 6
☐ AUG	8 20	7 7
☐ SEP	9 21	8 8
☐ OCT	10 22	9 9
☐ NOV	11 23	
☐ DEC	12 24	

10. Employment status. (Mark one)

☐ Employed full-time
☐ Employed part-time
☐ Unemployed
☐ Retired
☐ Other (specify) _____

11. How do you pay for services? (Mark one)

☐ Health Insurance
☐ Health Maintenance Organization (HMO)
☐ Medicaid
☐ Medicare
☐ Self pay
☐ Other (specify) _____

12. Person filling out this questionnaire:

☐ Client
☐ Family member of client
☐ Staff person
☐ Other (specify) _____

13. Was your treatment voluntary?

☐ Yes ☐ No

Name (optional): _____

THANK YOU FOR YOUR TIME AND EFFORT IN COMPLETING THIS SURVEY