

Service Evaluation Questionnaire

HOMEBASED SERVICES



At Crossroads we are committed to a quality program. Your feedback is very important to us. Thank you for taking the time to complete this form. Please seal it in the envelope provided and return.

Date: Child's Name:

Your Name: Relationship to Child:

Program: Worker:

Please complete the following sections:

PROGRAM EFFECTIVENESS	Very true	Mostly true	Somewhat true	Not true	Not true at all
Did Collaborative Problem Solving (CPS) help your child to deal more effectively with his/her problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did Collaborative Problem Solving (CPS) help you to feel better equipped to support your child?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Overall, how satisfied were you with CPS?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Yes, definitely	Probably would	Might or might not	Probably not	Definitely not
Would you recommend CPS to others?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any comments and/or suggestions:

CONFIDENTIALITY	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Were you satisfied that our program kept your problems and your child's problems confidential?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SERVICE EFFECTIVENESS	Very true	Mostly true	Somewhat true	Not true	Not true at all
Did the amount of visits per week meet your needs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did the amount of time per visit meet your needs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Never	1 time	2 times	3 times	More than 3 times
How many times did your worker cancel your visits during the service?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
If your worker cancelled, were you satisfied with alternate arrangements made?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When you called the person working with you most closely were you satisfied with the time it took to receive a call back?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Always	Usually	Sometimes	Rarely	Never
Was the person working with you flexible in setting hours which met your needs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you feel listened to and respected during the program?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Very satisfied	Mostly satisfied	Mildly satisfied	Not satisfied	Quite dissatisfied
Were you satisfied with the recommendations and follow-up plan that was developed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall, how satisfied were you with your assigned worker?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Was there a service that you wanted that you did not receive? Please tell us what it was:

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INVOLVEMENT IN SERVICE PLANNING AND DELIVERY – HOW INVOLVED WERE YOU IN (degree of involvement)	Very Involved	Mostly Involved	Somewhat Involved	Rarely Involved	Never Involved
Identifying strengths and prioritizing needs for service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Developing/agreeing on a service plan to address needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monitoring impact of service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing input on/agreeing to goals for treatment/service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being kept informed about the status of services/plans.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Determining readiness for discharge.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Identifying/agreeing with outcomes as a result of services.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any comments and/or suggestions:

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CHANGES AS A RESULT OF SERVICES – ANTICIPATED IMPACT OF SERVICES (To what extent did you experience these changes):	A great deal	To some extent	A little change	Very little change	No change
Needs/symptoms/severity of needs decreased over time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Functioning/Abilities increased over time.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Goals established for service were achieved.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Very pleased with outcomes	Mostly pleased with outcomes	Somewhat pleased with outcomes	Very little change	No change
Your overall perception of outcome as a result of service.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any comments and/or suggestions:

INDICATE THE DEGREE TO WHICH SERVICES WERE COMPREHENSIVE AND COORDINATED	Extremely well	Mostly well	Somewhat well	Not very well	Not at all
How well did the service plan include/address all of the needs identified.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How well were services coordinated/integrated across different providers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
To what extent did the mental health agency/service provider communicate with you and with other key stakeholders (e.g., school, physician) regarding needs, services and outcomes.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please include any comments and/or suggestions:

DESCRIBE REASONS FOR ENDING SERVICE (CHECK ALL THAT APPLY)

- Brief Services Only Required
 I/we no longer need/want service (describe: _____)
- I/we moved out of community
 I/we are no longer eligible due to age
 Service Plan is Complete
 Goals achieved
- No additional services required

Please include any comments and/or suggestions:

STATUS AT DISCHARGE

At this time I feel that I/we:

- Do not require any further service
- Require additional services but are not being offered or supported to access additional services
- Require additional services and are being offered or supported to access these services.

Please include any comments and/or suggestions:

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Would you agree to have your comments and your child’s comment posted on our website with no names or other identifiers?

- Yes No

Would you be interested in helping us advocate for Child and Youth Mental Health Services?

- Yes No

If yes, how would you prefer being contacted?

- via email @ the following address:
- via telephone @ the following number:

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Please know that this information will not be used for any purposes other than for helping us advocate for Child and Youth Mental Health

ADDITIONAL COMMENTS AND/OR SUGGESTIONS:

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