

SUA Resource Library:
Uniform Satisfaction Survey Materials



Foreword

In 2012, the Administration for Community Living (ACL), an operating division of the US Department of Health and Human Services, began a comprehensive evaluation of its National Family Caregiver Support Program (NFCSP). This was the first comprehensive federal evaluation of the NFCSP, which serves over 800,000 family caregivers annually. The NFCSP evaluation has three broad goals to benefit policy and program decision-making:

1. Collect and analyze information on program processes and site operations;
2. Evaluate program efficiency and cost issues for approaches best suited to specific contexts; and
3. Evaluate effectiveness of the program's contribution to family caregivers in terms of maintaining their health and well-being, improving their caregiving skills, and avoiding or delaying institutional care of the care recipient.

As part of the evaluation survey, State Units on Aging (SUAs) were asked to submit relevant documents if they answered 'yes' to any of the following five questions:

- Do you have a statewide task force, commission or coalition specifically to examine family caregiver issues?
- Have community needs assessments for caregiver support services been conducted?
- Does your state have a standardized caregiver assessment?
- Does your SUA conduct routine programmatic monitoring of the NFCSP program?
- Do you use a uniform caregiver satisfaction survey across all AAAs?

ACL received assessment tools and grouped them into the following categories:

1. Community Assessment Materials
2. General Customer Satisfaction Survey Materials
3. Grandparent Assessment Materials
4. High-Level Administrative Materials
5. Program Monitoring Materials
6. State Caregiver Assessments
7. State Care Recipient Assessments
8. Task Force Materials
9. Uniform Satisfaction Materials
10. Other Materials

While ACL does not specifically endorse these tools, we are sharing them because they may be helpful to other programs. For more information on the NFCSP please go to:

<http://www.aoa.acl.gov/>. For more information on the evaluation of the NFCSP please go to:
http://www.aoa.acl.gov/Program_Results/Program_Evaluation.aspx

Uniform Satisfaction Survey Materials

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**National Family Caregiver Support Program Caregiver Quality Assurance
Survey**

We are always looking to improve the quality of our program and we can not accomplish this without you. We appreciate your response to the survey.

1. Overall, how satisfied are you with the services that you and/or your family member receive?

Would you say ...

- Very satisfied**
- Somewhat satisfied**
- Somewhat dissatisfied**
- Very dissatisfied**

Comments:

2. To what extent do the services that you and/or family member receive help you to be a better caregiver? Would you say ...

- They help a lot**
- They help a little**
- They do not help**
- They make things worse**

Comments:

3. Have the services enabled you to provide care for your family member for a longer time than would have been possible without these services? Would you say

- Yes, definitely**
- Yes, I think so**
- No, I do not think so**
- No, definitely not**

Comments:

Background Questions (Optional)

4. How long have you been caring for your family member? ____Months ____Years

5. What is the age of the family member? _____

6. What is the gender of the family member? ____Female ____Male

7. What is your age? _____

8. What is your gender? ____Female ____Male

9. Do you have any kind of physical condition or disability that affects the kind of care that you can provide?

____ Yes ____ No

10. Ethnicity/Race :

- | | |
|---|---------------------------------|
| € American Indian or Alaska Native | € Asian |
| € Black or African American | € Hispanic or Latino |
| € Native Hawaiian or other Pacific Islander | € White, Not of Hispanic Origin |
| € Other (Specify Below) | € Not Collected |

11. As a caregiver, do you have needs that are not presently being met? Please use the space below or on the back to explain.

12. What can be done to improve the National Family Caregiver Support program, services and overall support to the caregiver? Please use the space below or on the back to explain.

13. If you would like us to contact you, please fill in the sections below:

Name _____ Phone _____

Thank you for taking the time to complete this survey. Your feedback is very important to us.

[Type text

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NFCSP CLIENT SATISFACTION SURVEY 2014

The Western Connecticut Area Agency on Aging (WCAAA) has been pleased to be able to give you assistance under the National Family Caregiver Support Program (NFCSP). Please take a moment to fill out this survey; your feedback will help us improve the program and enable us to provide services effectively to other families. *You do not need to put your name on this survey.*

1. How did you hear about the benefits offered through the National Family Caregiver Support Program by the WCAAA?
 Friend Radio/TV Hospital Municipal Agent
 Newspaper Brochure Visiting nurse Doctor
 Newsletter Infoline Case manager
 Other:

2. Was the WCAAA staff person courteous and helpful? yes no
3. Was the information about the program made clear to you? yes no
4. Were services arranged in a timely manner? yes no
5. Were you were satisfied with the services you received? yes no Please describe any problems you may have had:
6. How have the services you've been receiving helped you?
7. How have the services you've been receiving helped your caregiver?
8. Do you have suggestions for improving the program?
9. As a caregiver, please check workshops that would be of interest to you:
 Legal issues: living wills, advance healthcare directives, power of attorney, etc.
 Paying for in-home care How to identify depression, delirium, or dementia
 Information on: Alzheimer's other diseases of aging (which ones?):

 Home safety, minor modifications, and assistive medical equipment
 Death and dying Other topics?

10. What time of day would be best for you to attend a workshop? Are there circumstances that would prevent you from attending at some times of the day?
11. Other comments? (Use the back of the sheet if necessary.)

Thank you for taking time to fill out this survey! (Please return by September 20, 2013)

Please return to **WCAAA, 84 Progress Lane, Waterbury CT 06705**

For more information or if you have questions, call Marissa or Sandy at 1-800-994-9422 or 203-757-5449.

**Senior Resources - Agency on Aging
National Family Caregiver Support Program**

The National Family Caregiver Support Program is meant to be a brief, temporary respite for you, the caregiver, by reducing your stress so you may continue to care for your loved one.

2013 – 14 Caregiver Consumer Satisfaction Questionnaire

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much; we really appreciate your help.

Please Circle your answer:

How would you rate the quality of service you have received?

Excellent Good Fair Poor

Did you get the kind of service you wanted?

No, definitely No, not really Yes, generally Yes, definitely

To what extent has our program met your needs?

Almost all of my needs have been met Most of my needs have been met Only a few of my needs have been met None of my needs have been met

If a friend were in need of similar help, would you recommend our program to him/her?

No, definitely not No, I don't think so Yes, I think so Yes, definitely

How satisfied are you with the amount of help you have received?

Quite dissatisfied Indifferent or mildly dissatisfied Mostly satisfied Very satisfied

Have the services you received helped you deal more effectively with your concerns?

Yes, they helped a great deal Yes, they helped No, they really didn't help No, they seemed to make things worse

In an overall general sense, how satisfied are you with the service you have received?

Very satisfied Mostly satisfied Indifferent or mildly dissatisfied Quite dissatisfied

If you were to seek help again, would you come back to our program?

No, definitely not No, I don't think so Yes, I think so Yes definitely

**Senior Resources - Agency on Aging
National Family Caregiver Support Program**

Once this form is received, your request will be placed on a waiting list. This does not guarantee acceptance on this program; however, it does allow for a review of need. **Please PRINT and fill out completely (an incomplete reconsideration request will delay placement on the waiting list).**

**CAREGIVER RECONSIDERATION FORM 2014-2015
(October 2014 – September 2015)**

Name of Caregiver: _____ Name of Care Recipient: _____

Please indicate your service requests.

Service	Agency Currently Providing Service

How is the **care recipient** able to function now? Please indicate with an “x” the level of assistance needed in the following areas.

DAILY ACTIVITIES	INDEPENDENT YES OR NO	DAILY ACTIVITIES	INDEPENDENT YES OR NO
Personal Hygiene: bathing, grooming and oral care		Taking Medications	
Dressing: physically dress self and make appropriate clothing decisions		Housework	
Eating: feed oneself		Using Phone	
Maintain Continence: the mental/physical ability to use bathroom		Using Transportation	
Transferring: moving oneself from seated to standing and getting in/out bed		Managing Money	
		Shopping	

Have there been any significant changes in the **care recipient's** status (new diagnosis, safety risk, combative, cognitive or mental impairment, etc.)? Yes No

If Yes, Please state change(s) _____

Recent diagnosis: _____ Recent hospitalization: _____ Surgeries: _____

If there has been a change in address/phone for the **care recipient**, please state changes here:

Is the **care recipient** receiving or applying for:

- Medicaid (Title 19)
- CT Home Care Program for Elders (CCCI or SCAAA) Name of Case Manager: _____
- Alzheimer's Respite Care Program

Comments/other information:

Please update the financial information listed below. You may be asked to voluntarily cost share toward service granted based on the care recipient's income.

Care Recipient INCOME

		Joint
Social Security (subtract Medicare premium), SSI, Railroad Retirement income	\$ _____	_____
Pensions, retirement income, annuities, Veteran's benefits	\$ _____	_____
Interest and dividends	\$ _____	_____
Other income (wages, net rental income, Non-taxable income)	\$ _____	_____
TOTAL INCOME	\$ _____	

If spouse has income separate from the applicant, please indicate approx. amount: \$ _____

ASSETS

Please include joint assets as well as those in care recipient's name only. Joint

Checking/savings accounts, IRAs, CDs, Stocks/bonds	\$ _____	_____
	\$ _____	_____
	\$ _____	_____
TOTAL ASSETS	\$ _____	

If spouse has assets separate from the care recipient, please indicate approximate amount: \$ _____

I certify that the information on this form is true, accurate, and complete.

SIGNATURE OF CAREGIVER

DATE

Have there been any significant changes this past year for you, as the **caregiver** (change in medical condition: new diagnosis and/or increase in chronic condition, stress level, hospitalization, loss of support, losing work directly related to caregiving, etc.)? Yes No

If Yes, Please state change(s) _____

Has there been a change in address/phone number for you, the **caregiver**, please state changes here:

Emergency Contact if you, the caregiver, cannot be reached:

Name _____ Phone _____ Relation _____

**National Family Caregiver Support Program Caregiver
Quality Assurance Survey 2014**

We are always looking to improve the quality of our program and we cannot accomplish this without you. We would appreciate your response to the following survey. Please complete and return as soon as possible in the enclosed envelope.

1. Overall, how satisfied are you with the respite service(s) and/or item(s) that you and/or your family member received?

Would you say ...

- Very satisfied
 Somewhat satisfied
 Somewhat dissatisfied
 Very dissatisfied

Comments:

2. To what extent did the service(s)/item(s) that you and/or your family member received help you as a caregiver?

Would you say...

- They helped a lot
 They helped a little
 They did not help
 They made things worse

Comments:

3. Have the service(s)/item(s) enabled you to provide care for your family member for a longer time than would have been possible without these services?

Would you say...

- Yes, definitely
 Yes, I think so
 No, I do not think so
 No, definitely not

Comments:

2014 SURVEY FOR CARE MANAGEMENT SERVICES

1. Were you treated in a courteous and professional manner by the Care Manager?

Yes No Not Sure

2. Did you feel she understood the type of care you need to help you stay at home?

Yes No Not Sure

3. Was the Care Manager helpful in explaining the services available to meet your care needs?

Yes No Not Sure

4. Was the Care Manager helpful in assisting you to arrange for services to meet your needs?

Yes No Not Sure

5. Were you satisfied with your participation in developing your care plan?

Yes No Not Sure

6. Do you have any suggestions to improve our care management service?

Yes No Not Sure

If yes, please explain:

7. Would you use care management services if you needed them again?

Yes No Not Sure



North Central Area Agency on Aging
 151 New Park Avenue, Box 75
 Hartford, CT 06106

CONSUMER SATISFACTION QUESTIONNAIRE 2014-15

The North Central Area Agency on Aging seeks your feedback on the Connecticut National Family Caregiver Support Program. During this fiscal year, our records indicate that you received items and/or services from us. If you would please take a moment to complete this brief survey we would be most appreciative.

If you would like this questionnaire to be sent in an alternative format, or would prefer to answer this questionnaire by telephone, please contact **Damaris-DeLeon at (860) 724-6443 x 289.**

- Overall, how satisfied are you with the item(s) that you and/or your family member received?

Not Satisfied	Very Satisfied
1 2 3 4 5	

- To what extent have the service(s)/item(s) that you and/or your family member received:

	Not very much			A great deal	
Reduced your stress	1	2	3	4	5
Saved you money	1	2	3	4	5
Increased your family member's safety	1	2	3	4	5
Improved your quality of life	1	2	3	4	5
Improved your family member's	1	2	3	4	5

Quality of life	1	2	3	4	5
Assisted your family member	1	2	3	4	5
To stay at home	1	2	3	4	5

4. How did you hear about program? Who referred you to the program?

5. Can you think of ways in which our services could be improved to assist older adults and their families?

6. Is there anything else you would like to tell us about our program?

Optional Information:

Your name: _____

Mailing Address: _____

Telephone: (H) _____

Please return this survey to:

NORTH CENTRAL AREA AGENCY ON AGING
National Family Caregiver Support Program
151 New Park Avenue, Box 75
Hartford, CT 06106
Attn: Damaris DeLeon

**Attachment B-8 – HCBS Caregiver Services Consumer Survey
June 2011 - FINAL**

Item #	HCBS Caregiver Services Survey Questions	Answer Options
As a result of the Caregiver Services, do you...		<ul style="list-style-type: none"> • Yes • No
1.	Have more time for personal activities? (For example: church, shopping for yourself, walking, reading, exercising, movies, talking with friends)	
2.	Have more time to do daily activities or chores? (For example: house cleaning, yard work, shopping for groceries, running errands, picking up medications)	
3.	Feel less stress?	
4.	Have a clearer understanding of how to get the services you and your Care Receiver need?	
5.	Know more about your Care Receiver's condition or illness?	
6.	Feel more confident in providing care to your Care Receiver?	
7.	Have the Caregiver Services helped you to provide care for a longer period of time than would have been possible without these services?	
8.	Would you say Caregiver Services have helped you be a better caregiver?	
9.	Have the Caregiver Services helped your Care Receiver to continue to be able to live at home?	
10.	Overall, how satisfied are you with the Caregiver Services you receive?	<ul style="list-style-type: none"> • Satisfied • Somewhat Satisfied • Dissatisfied
11.	Who would you contact first if you had a problem with the Caregiver Services?	<ul style="list-style-type: none"> • The Aide's or Worker's Supervisor • Case Manager's Supervisor or Agency • Area Agency on Aging • Division of Aging Services • Do Not Know • Others: _____
12.	In your opinion, how could we improve Caregiver Services for you? Please mark all that apply.	<ul style="list-style-type: none"> • Need the same aides/workers each time. • Need better trained aides/workers. • I would like to choose my aides/workers. • Need the aides/workers to do more for me. • Need the aides/workers to arrive on time as scheduled.

**Attachment B-8 – HCBS Caregiver Services Consumer Survey
June 2011 - FINAL**

Item #	HCBS Caregiver Services Survey Questions	Answer Options
		<ul style="list-style-type: none"> • Need the aides/workers for more hours and/or more days. • Need the aides/workers to do things the way I want them to be done. • Need aides/workers to stay the full amount of time scheduled. • Need more information on my Care Receiver’s illness or how to provide better care.
13.	Please tell us any other suggestions you have to improve the quality of Personal Care Services you receive.	Comments:

Note: If the survey is to be administered by mail, please do *not* ask the consumer to identify him/herself, *unless* he or she wishes to be contacted for follow-up. Add lines at the end of the survey for the consumer to indicate voluntarily a desire for a contact and to provide his or her name and telephone contact information.

Kinship Care Participant Survey

Background:

The Kinship Care Participant Survey tool is to be used twice annually (March and September) to gauge participants' perceptions of the program and the program's impact on Kinship families. If a participant leaves the program prior to the six month point, or prior to an annual review, the staff should attempt to use the survey as an exit interview.

The primary goal of the survey is to determine the extent to which the program has made a positive difference in the consumers' experience as grandparents or other relatives raising grandchildren or others in their care. A Likert scale is used to measure attitudes, preferences, and subjective reactions. Likert scales help get at the emotional and preferential responses people have to the program and services. Staff may administer the scale through an interview or provide the survey to program participants to self-rate their experience. Date the form at the space provided at the bottom.

The Division has formulated survey questions that will capture data that address the major goals and desired outcomes of the program described in the guidelines, including questions adapted from the Family Empowerment Questionnaire.

Data Analysis:

Within fifteen (15) business days of the end of each survey period (March and October), each AAA should enter survey response data into AIMS.

Using the Kinship Care Quarterly Narrative Report (Appendix 216-C), each AAA should describe the process by which the survey was conducted for that period, significant findings of the survey, and any actions planned as a result of the survey data, including how the information will be used to improve the program and to advocate for additional resources and services. If there are an unusually high proportion of non-respondents in a given area, address this in your analysis.

KINSHIP CARE SURVEY

Below is a list of services and resources. Please tell us whether you used any of these services or resources within the last 6 months and, if so, please indicate your level of satisfaction with the services you received.	Did You Use this Service?		If So, Were You Satisfied with the Service?	
	Y	N	Y	N
Legal Assistance				
Financial Assistance				
Housing Resources				
Mental/Behavioral Health Services				
Food and Nutrition Services				
Child Care Services				
Physical Health Care Services/Medical Services				
School/Educational Resources				
Leisure/Recreational Resources				

If you had any difficulty accessing any service, or were not satisfied with the service, please tell us about your experience: _____

As a result of participating in Kinship Care programs or services, please tell whether you agree or disagree with each of the following statements:	Strongly Agree	Agree	Disagree	Strongly Disagree
I feel that I am better able to cope with caring for the children I am raising than before I became involved in Kinship Care services and activities.				
I do not feel as stressed out as I used to.				
I am enjoying life more now.				
I think that I will be able to continue raising child(ren) in my care.				
I plan to continue to participate in Kinship Care activities.				
I feel as if my overall health and sense of well-being have improved.				
I would recommend the Kinship Care program to others who are in the same situation as myself.				

Below are a number of statements that describes how a grandparent raising a grandchild(ren) – or other relative caregiver - might feel about his or her situation. For each statement, please tell which response best describe how that statement applies to you:	Very True	Mostly True	Somewhat True	Mostly Not True	Not at all True
When problems arise with my grandchild, I handle them pretty well.					
I feel confident in my ability to help my grandchild grow and develop.					
I know what to do when there are problems with my grandchild.					
I am able to get information to help me better understand my grandchild.					
When I need help with other problems in my family, I am able to ask for help from others.					
When necessary, I will look for services for my grandchild and family.					

Are there any service or services that you need but have not been able to get?
 ___ No ___ Yes - please describe what service or services: _____

PLEASE PROVIDE THE FOLLOWING INFORMATION:

Gender: ___ Male ___ Female County of Residence: _____

Race: ___ American Indian/Alaskan Native ___ Asian
 ___ African-American ___ White
 ___ Native Hawaiian/Pacific Islander ___ Other

Marital Status: ___ Married ___ Widowed ___ Divorced/Separated
 ___ Domestic Partner ___ Single

Age: ___ 55 or younger ___ 56-64 ___ 65-74 ___ 75+

How many grandchildren are you caring for: ___ 1 ___ 2-3 ___ 4-5 ___ more than 5

How long have you been caring for your grandchild or grandchildren:
 ___ less than 1 year ___ 1-2 years ___ 3-5 years ___ more than 5 years

Household Income per year:
 ___ less than \$9,999 ___ \$10,000 - \$19,999 ___ \$20,000 - \$29,999
 ___ \$30,000 - \$39,999 ___ \$40,000 - \$49,999 ___ \$50,000 or more
 ___ Prefer not to disclose

Date Completed: _____

KDADS QI - OAA III E CAREGIVER CUSTOMER INTERVIEW PROTOCOL

Number	1
Question	How did you hear about the area agency on aging and the caregiver services?
Measures	(1) Family/friends (2) Newspaper (3) TV (4) Phone book (5) Community event (6) Other: _____ (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference	Data Collection

Number	2
Question	Have you had contact with the area agency on aging during the past 3 months?
Measures	(1) Yes (2) No (3) If no, approximately when did you have contact? (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

Number	3
Question	If/when you had contact with the AAA staff, were they friendly and helpful?
Measures	(1) Yes (2) No (3) If no, explain _____ (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference	Data Collection

Number	4
Question	If you left a message for the AAA, did they return your call timely? (within a day or two?)
Measures	(1) Yes (2) No - Explain: _____ (7) Unsure/Doesn't want to answer (9) Not applicable (no contact)
Policy Reference	Data Collection

KDADS QI - OAA III E CAREGIVER CUSTOMER INTERVIEW PROTOCOL

Number	5
Question	What caregiver information and/or services have you received from the AAA?
Measures	(1) Information about caring for a loved one (2) Information for yourself as the caregiver (3) Grandparents raising grandchildren assistance (4) Other _____ (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't recall contact with AAA)
Policy Reference	Data Collection

Number	6
Question	Do you feel the information/services provided were:
Measures	(1) Very Helpful (2) Somewhat helpful (3) Not helpful (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't recall getting services)
Policy Reference(s)	Data Collection

Number	7
Question	Do you have any concerns about the information/services received?
Measures	(1) Yes, Explain _____ (2) No (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

Number	8
Question	Do you believe the information/services provided has helped you and the person you provide care for remain independent at home?
Measures	(1) Yes (2) No (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

KDADS QI - OAA III E CAREGIVER CUSTOMER INTERVIEW PROTOCOL

Number	9
Question	Would you recommend these services to a friend or relative?
Measures	(1) Yes (2) No (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

Number	10
Question	If you had a complaint about the customer service you received from the AAA, how would you handle it or who would you contact?
Measures	(1) Staff supervisor (2) Head of agency (3) Discuss with person involved (4) Not do anything (5) Not have contact with agency again (6) Other _____ (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

Number	11
Question	Do you feel safe at home?
Measures	(1) Yes (2) No, Explain _____ (7) Unsure/Doesn't want to answer
Policy Reference(s)	Data Collection

Number	12
Question	Do you have any suggestions for or comments about the Caregiver Program?
Measures	(1) Yes, Explain _____ (2) No (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't remember contact)
Policy Reference(s)	Data Collection

KDADS QI - OAA III E CAREGIVER CUSTOMER INTERVIEW PROTOCOL

Number	13
Question	What item was purchased for you?
Measures	ASK ONLY OF THOSE ON THE FLEX SERVICE LIST (1) List item _____ (7) Unsure/Doesn't want to answer (9) Not applicable (doesn't recall item being purchased)
Policy Reference(s)	Data Collection

Number	14
Question	How did this item help you?
Measures	ASK ONLY OF THOSE ON THE FLEX SERVICE LIST (1) Remain independent in the home (2) Relief for caregiver (3) Assistance with grandchildren (4) Other, _____ (7) Unsure/Doesn't want to answer (9) Not applicable
Policy Reference	Data Collection

Number	15
Question	If this item had not been purchased for you thru the AAA, how would you have managed without it?
Measures	ASK ONLY OF THOSE ON THE FLEX SERVICE LIST (1) Family would have purchased item. (2) Church or other charitable organization would have purchased item. (3) Would have done without. (7) Unsure/Doesn't want to answer
Policy Reference(s)	Data Collection

Number	16
Question	If you had not been able to secure this item, how would it have affected your everyday life?
Measures	ASK ONLY OF THOSE ON THE FLEX SERVICE LIST (1) No impact (2) Decreased quality of life (3) Health impact (4) Safety in the home (5) Other _____ (7) Unsure/Doesn't want to answer
Policy Reference(s)	Data Collection

Family Caregiver Support Program Satisfaction Survey

According to our records you have received the following services.

- In person or phone consultation to discuss your caregiving situation
- Information and assistance to connect you with resources and services
- Assistance in receiving respite (a break from your caregiving)
- Assistance/subsidy toward adaptive equipment, assistive technology or other supplemental support
- Support Group Education/training (other)

1. How long have you received caregiver support services from our agency?

- Less than 3 months 3-5 months 6-12 months More than 1 year

2. How helpful was meeting/consulting with (fill in name)?

- Very helpful Helpful Somewhat helpful Not helpful

3. Did you find the caregiver action plan useful?

- Yes No Not applicable/did not receive a plan

4. Of the services that you received through the Family Caregiver Program which are more useful?

<input type="checkbox"/> In person consultation/meeting(s)	<input type="checkbox"/> Phone consultation
<input type="checkbox"/> Information/assistance/referral to resources and services	<input type="checkbox"/> Financial assistance/subsidy toward i.e. adaptive equipment, assistive technology
<input type="checkbox"/> Caregiver education/training	<input type="checkbox"/> Support group
<input type="checkbox"/> Respite – a break from caregiving	<input type="checkbox"/> Other (write in)

5. As a result of the Family Caregiver Program services, do you:

	Yes	No	Unsure	Not Applicable
a) have a better understanding how to get needed services?				
b) know more about the condition or illness(es) of the care recipient?				
c) feel more confident in providing care?				
d) believe the services enabled you to provide care longer?				
e) feel better able to make decisions and solve problems related to your caregiving?				
f) feel better able to cope with stress?				
g) take more time for your personal health and well-being?				

6. How would you describe your overall experience with the caregiver support services?

- Excellent** **Good** **Fair** **Poor**

Date _____

Optional information: see over
Thank you for completing this survey.

Consumer # _____

Comments:

I would like someone to contact me regarding this survey. **Yes** **No**

I would like additional assistance and/or information regarding the following:

If you would like to be contacted, please complete below.

Name _____

Telephone # _____

Address _____

Email _____

Thank you

MBA Caregiver Outcomes Survey Questionnaire

Region:

Year:

Type: Frequency Counts for All Services

Total number of caregivers surveyed (equals number of persons served) III-B and III-E

Total number of completed caregiver survey returned

Response rate

%

Caregiver Demographic Information

1. Gender

Female

Male

2. Race/

White

African American or Black

Asian

American Indian or Alaska Native

Native Hawaiian or Other Pacific Islander

Other

3. Are you Hispanic or Latino?

Yes

No

4. Age Group

Under 60

60 - 74

75 - 84

85 or above

5. Household Annual Income

Less than Federal Poverty Guidelines for single person household

Less than Federal Poverty Guidelines for 2 person household

Frequency counts for Caregiver Services

(1) How long have you received caregiver services?

Less than 3 months

3 to 6 months

6 to 12 months

More than a year

(2) Has a caregiver service helped you cope better?

Not coping better

Coping somewhat better

Coping much better

- (3) Has a caregiver service improved your ability to provide care?
Not more able to provide care
Somewhat more able to provide care
Much more able to provide care
- (4) Do you believe that caregiver services will help you provide care longer?
Will not help me provide care longer
Will help me provide care longer
Will help me provide care much longer
- (5) Are you (or care receiver) receiving any of the following?
Respite
Support group
Counseling/Support Groups
Education/Training
Homemaker
Home delivered meals
Caregiver support at work
Transportation
Outside chore help
Education about caregiving

- (6) Narrative/qualitative summary:

Examples of Improvement:

Other Feedback:

CAREGIVER SUPPORT SATISFACTION SURVEY

ZIP CODE: _____

YOUR AGE: _____

Age of Person in Care: _____

1. Are you caring for a:

- Person 60 and older
- Person with Alzheimer's or Dementia
- Related child 18 and under
- Adult or Child with Disability

2. How did you first find out about the supportive services you received?

Comments: _____

3. How helpful was your contact with the Family Caregiver Support Program?

- Very Helpful Somewhat Helpful Not Helpful

Comments: _____

4. Which of these services have you received? Mark all that apply

- Information about services
- Caregiver Training
- Respite (A break from Caregiving)
- Support Group
- Help in obtaining available services
- Other: (i.e. medical equipment)

If Other, please explain: _____

5. Overall, how would you rate the services you received?

- Excellent Good Fair Poor

Comments: _____

6. If you received respite, how well did it meet your need? (Mark all that apply)

- I received respite when I needed it
- The amount of time given was adequate
- I needed a longer break
- I was comfortable with my respite care provider
- Other: (Please explain) _____

7. Did the support services received by you or the person for whom you provide care, help you be a better caregiver?

YES

NO

Comments: _____

8. Did the services you received help you keep your loved one at home?

YES

NO

9. As a caregiver, I am experiencing the following: (Mark all that apply)

Feeling like I can't give care much longer

Depression

Not enough time for myself

Stress

Not enough time for my family

Anger

Interference with my work

Physically fatigued

Effects on my family relationships

Feeling out of control

Interference with my privacy

Isolation

Conflicts with my social life

Financial burdens

Strained relations with the person I care for

Other: (describe below)

10. As a caregiver the most important service I could receive is: _____

11. In my role as a caregiver, I find satisfaction in: _____

Contact Information: (optional)

Name: _____

Address _____

City _____

State _____

ZIP _____

Phone: () _____

Email _____

Thank you for your time completing this survey. The information you provide will help us in making decisions regarding services for the Family Caregiver Support Program.

PLEASE RETURN IN THE ENCLOSED ENVELOPE

CAREGIVER RESPITE GRANT CONSUMER SURVEY

Town of residence: _____ County of residence: _____

Please indicate your opinion on the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
The respite grant gives me a break from my caregiving responsibilities.				
The services I obtain with the respite grant help me maintain my physical health.				
The services I obtain with the respite grant help me maintain my emotional well-being.				
The respite grant helped me take care of myself				
The services I obtain with the respite grant improve my ability to care for my family member.				
The respite grant helps me continue caregiving so my family member can live in the place of his/her choice.				
The respite grant provided me with the flexibility to choose helpful ways to attain respite.				
The respite grant helped me to use supports such as Powerful Tools for Caregivers, Memory Café, Alzheimer’s Association supports, and others				

Type of respite grant received:

Dementia Respite Grant

Family Caregiver Respite Grant for Caregivers of Older Adults

Family Caregiver Respite Grant for Older Relative Caregivers of Children

Please use the space on the back of this survey for any comments you would like to make or if you wish to be contacted about a specific problem or concern about the respite grant.→→→→

Thank you for taking the time to complete this survey. Please return this survey in the pre-addressed, pre-stamped envelope that you received with the survey by May 31, 2014.

Comments:

OPTIONAL

Please note: Your responses to this survey are anonymous and confidential. However, if you would like help with a problem or concern, you may sign below and let us know how to reach you. Please indicate who you would like to have contact you:

_____ Department of Disabilities, Aging & Independent Living,
Division of Disability and Aging Services staff

_____ Area Agency on Aging staff

Your name: (print) _____

Address: _____

Phone number: _____

Email: _____

Best time to contact: _____