

Administrative Use Only

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> Aspirus | <input type="checkbox"/> FHC |
| <input type="checkbox"/> HOPE CC | <input type="checkbox"/> Options/Koinonia |
| <input type="checkbox"/> FCP AODA | <input type="checkbox"/> Price Co |
| <input type="checkbox"/> Iron Co | <input type="checkbox"/> Sokaogon Comm |
| <input type="checkbox"/> LDF FRC | <input type="checkbox"/> HSC |

PATIENT SATISFACTION SURVEY

Please rate your level of agreement with the following statements about the treatment and support services you received at this facility. Select "Does Not Apply" if the statement does not apply to you or if you received the service somewhere else.

| Statement | Agree | Neutral / Uncertain | Disagree | Does Not Apply |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. I am satisfied with... | | | | |
| The overall treatment program. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Individual counseling. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Group counseling. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication-assisted treatment (MAT), such as Suboxone or Vivitrol. <i>Please indicate where MAT received or select "Does Not Apply"</i> <input type="checkbox"/> Family Health Center <input type="checkbox"/> Aspirus <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Care coordination services. <i>Please indicate who provided services or select "Does Not Apply"</i> <i>May select more than one</i> <input type="checkbox"/> HOPE <input type="checkbox"/> Family Health Center <input type="checkbox"/> Other | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Appointments were offered at times that worked well for me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Information about my treatment was clearly explained. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. I understood expectations of the treatment program. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. I was actively involved in developing my treatment and/or service plan. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Treatment/services I received helped me to understand and manage my substance use disorder. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. I felt safe while receiving treatment/services. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Providers and staff were professional and welcoming. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Providers and staff listened to me. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. I felt motivated and encouraged by providers and staff. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Please provide the name of anyone who was particularly helpful to you: | | | | |
| | | | | |
| 12. Services were available to help me deal with financial concerns. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. The facility felt welcoming and safe. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14. What part of treatment or which services made the biggest difference for you?

15. If you could change one thing to improve your experience, what would it be?

Thank you for taking the time to complete this survey.

If you would like to share additional comments, you may:

1. Visit the HOPE Consortium website at hopeconsortium.org and click on the Contact tab or type <https://hopeconsortium.org/contact-us-2/> directly into your browser for the most up-to-date contact information.

OR

2. Provide your name and phone number and/or email address below and someone from the HOPE Consortium will contact you. Sharing this information is **optional**.

Name: _____

Phone number and/or email address: _____