

Lakeshore Regional Entity's Customer Satisfaction Survey

Need help with this survey? Contact your CMH Customer Services Representative

CMH Name: _____

Date: _____

Provider Agency (if applicable): _____

Circle the words that best describe the person receiving services.

Services For: <i>Mark all that apply</i>	Mental Illness	Intellectual and/or Developmental Disability	Substance Use Disorders
I have been in services for:	Less than a year	More than a year	

This section is optional:

Gender	Male		Female		Prefer not to answer		Prefer to self-describe: _____	
Age	Less than 18		Between 18-60		Over age 60			
Race / Ethnicity <i>Mark all that apply</i>	Asian	Black / African American	Caucasian/ White	Hispanic/ Latinx	Native American	Pacific Islander	Prefer not to answer	Prefer to self-describe: _____

How are your services?

What you tell us will help the Lakeshore Regional Entity (LRE) provide the best services possible.

Circle the best answer based on your experience.

This survey is anonymous unless you identify yourself on the last page. Responses will not affect your current services.

Access / Availability Measures		Strongly Agree	Agree	Mildly Agree	Mildly Disagree	Disagree	Strongly Disagree	Not Applicable
1:	When I first asked for services, it went well.	6	5	4	3	2	1	NA
2:	If I did not receive the services I asked for, I was given other choices.	6	5	4	3	2	1	NA
3:	Staff called me back within 24 hours.	6	5	4	3	2	1	NA
4:	Dates and times of my services worked for me.	6	5	4	3	2	1	NA
5	The place of my services worked for me.	6	5	4	3	2	1	NA
Quality Measures		Strongly Agree	Agree	Mildly Agree	Mildly Disagree	Disagree	Strongly Disagree	Not Applicable
6	I decided the goals for my treatment plan.	6	5	4	3	2	1	NA
7	I feel included in working on my treatment plan.	6	5	4	3	2	1	NA
8	I felt comfortable asking questions.	6	5	4	3	2	1	NA
9	Staff helped me get information to better deal with my illness or disability.	6	5	4	3	2	1	NA
10	Staff accept me for who I am.	6	5	4	3	2	1	NA
Outcome Measures		Strongly Agree	Agree	Mildly Agree	Mildly Disagree	Disagree	Strongly Disagree	Not Applicable
11	Services helped me deal better with my illness or disability.	6	5	4	3	2	1	NA
12	I am satisfied with my services.	6	5	4	3	2	1	NA

Please complete both sides of this form

Long Term Services (e.g., Residential, ACT, Support Coordination, Case Management)		Strongly Agree	Agree	Mildly Agree	Mildly Disagree	Disagree	Strongly Disagree	Not Applicable
13	I am satisfied with my support coordinator / case manager.	6	5	4	3	2	1	NA
14	I am satisfied with my current housing situation.	6	5	4	3	2	1	NA
15	My treatment team works well together to provide good care for me.	6	5	4	3	2	1	NA
16	My services helped me improve relationships with friends, family and community members.	6	5	4	3	2	1	NA

Telehealth Services
(e.g., video calls, phone, texting)

How many of your services did you receive by telehealth? (e.g., video call, telephone, texting)	All	Most	Some	Few	One	None	
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Please tell us about your telehealth services		Strongly Agree	Agree	Mildly Agree	Mildly Disagree	Disagree	Strongly Disagree	Not Applicable
17	I am able to use telehealth services without technical problems.	6	5	4	3	2	1	NA
18	Staff helped me when I had problems using telehealth.	6	5	4	3	2	1	NA
19	I would like to use telehealth for future appointments.	6	5	4	3	2	1	NA
20	Overall, I am satisfied with using telehealth for my services.	6	5	4	3	2	1	NA

Comment Section

Please tell us what you liked or did not like about your services. Was something missing from your services?

Do you have concerns or problems about your services?

Yes: _____ No: _____ → Thank you for your time.



If YES, please print your name and phone number and we will contact you.

_____ () _____
Name Phone