CHOICES Satisfaction Survey

Hello!

We would like to hear from you about how we are doing. Please complete this form and put it in the Consumer Survey Box at the reception desk or return to us in the self-addressed stamped envelope we sent to you if you have gotten this in the mail. Your responses are important to us and will be kept confidential.

Sincerely,

Lisa Noland

Chief Executive Officer Date _____

Please **select the program** you would like to review	ACT	ICM	PEER	PEER BRIDGER	PATH	ALL

Were the services you received:	Excellent	Very Good	Good	Fair	Poor	Does Note Apply
1. Appointment available within a reasonable amount of time?	5	4	3	2	1	N/A
2. Greeted in a prompt and courteous way?	5	4	3	2	1	N/A
3. Phone calls were answered and returned within 48 hours?	5	4	3	2	1	N/A
4. Treated respectfully?	5	4	3	2	1	N/A
5. I felt involved in and listened to during my treatment planning.	5	4	3	2	1	N/A
6. I feel that CHOICES has helped me in my recovery.	5	4	3	2	1	N/A

How did CHOICES help you on your path toward healing?

What services would you like to see CHOICES provide? How can CHOICES improve our services?

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