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 cannot 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.
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 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.
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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Agency Currently Providing Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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**

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security (subtract Medicare premium), SSI, Railroad Retirement income</td>
<td>$ ________</td>
</tr>
<tr>
<td>Pensions, retirement income, annuities, Veteran’s benefits</td>
<td>$ ________</td>
</tr>
<tr>
<td>Interest and dividends</td>
<td>$ ________</td>
</tr>
<tr>
<td>Other income (wages, net rental income, Non-taxable income)</td>
<td>$ ________</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Checking/savings accounts, IRAs, CDs, Stocks/bonds</td>
<td>$ ________</td>
</tr>
<tr>
<td></td>
<td>$ ________</td>
</tr>
<tr>
<td></td>
<td>$ ________</td>
</tr>
</tbody>
</table>

**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, loosing 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
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.

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

<table>
<thead>
<tr>
<th>Not Satisfied</th>
<th>Very Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Reduced your stress</th>
<th>Not very much</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Saved you money</th>
<th>Not very much</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Increased your family member's safety</th>
<th>Not very much</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improved your quality of life</th>
<th>Not very much</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Improved your family member's</th>
<th>Not very much</th>
<th>A great deal</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 4 5</td>
<td>1 2 3 4 5</td>
<td></td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Item #</th>
<th>HCBS Caregiver Services Survey Questions</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>As a result of the Caregiver Services, do you…</td>
<td>Yes, No</td>
</tr>
<tr>
<td>2.</td>
<td>Have more time for personal activities? (For example: church, shopping for yourself, walking, reading, exercising, movies, talking with friends)</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Have more time to do daily activities or chores? (For example: house cleaning, yard work, shopping for groceries, running errands, picking up medications)</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Feel less stress?</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Have a clearer understanding of how to get the services you and your Care Receiver need?</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Know more about your Care Receiver’s condition or illness?</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Feel more confident in providing care to your Care Receiver?</td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Have the Caregiver Services helped you to provide care for a longer period of time than would have been possible without these services?</td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Would you say Caregiver Services have helped you be a better caregiver?</td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Have the Caregiver Services helped your Care Receiver to continue to be able to live at home?</td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Overall, how satisfied are you with the Caregiver Services you receive?</td>
<td>Satisfied, Somewhat Satisfied, Dissatisfied</td>
</tr>
<tr>
<td>12.</td>
<td>Who would you contact first if you had a problem with the Caregiver Services?</td>
<td>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: ________________</td>
</tr>
<tr>
<td>13.</td>
<td>In your opinion, how could we improve Caregiver Services for you? Please mark all that apply.</td>
<td>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.</td>
</tr>
<tr>
<td>Item #</td>
<td>HCBS Caregiver Services Survey Questions</td>
<td>Answer Options</td>
</tr>
<tr>
<td>--------</td>
<td>------------------------------------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| 13.    | Please tell us any other suggestions you have to improve the quality of Personal Care Services you receive. | • 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.  
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.

<table>
<thead>
<tr>
<th>Service</th>
<th>Did You Use this Service?</th>
<th>If So, Were You Satisfied with the Service?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legal Assistance</td>
<td>Y N</td>
<td>Y N</td>
</tr>
<tr>
<td>Financial Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental/Behavioral Health Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food and Nutrition Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Health Care Services/Medical Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School/Educational Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leisure/Recreational Resources</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not feel as stressed out as I used to.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am enjoying life more now.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think that I will be able to continue raising child(ren) in my care.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I plan to continue to participate in Kinship Care activities.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel as if my overall health and sense of well-being have improved.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I would recommend the Kinship Care program to others who are in the same situation as myself.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Below are a number of statements that describe 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:

<table>
<thead>
<tr>
<th>Statement</th>
<th>Very True</th>
<th>Mostly True</th>
<th>Somewhat True</th>
<th>Mostly Not True</th>
<th>Not at all True</th>
</tr>
</thead>
<tbody>
<tr>
<td>When problems arise with my grandchild, I handle them pretty well.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I feel confident in my ability to help my grandchild grow and develop.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I know what to do when there are problems with my grandchild.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I am able to get information to help me better understand my grandchild.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When I need help with other problems in my family, I am able to ask for help from others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>When necessary, I will look for services for my grandchild and family.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Are there any service or services that you need but have not been able to get?

### 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:** ___________________
<table>
<thead>
<tr>
<th>Number</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>How did you hear about the area agency on aging and the caregiver services?</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Have you had contact with the area agency on aging during the past 3 months?</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>If/when you had contact with the AAA staff, were they friendly and helpful?</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>If you left a message for the AAA, did they return your call timely? (within a day or two?)</td>
</tr>
</tbody>
</table>
| Measures | (1) Yes  
(2) No - Explain: ____________________________  
(7) Unsure/Doesn’t want to answer  
(9) Not applicable (no contact) |
<p>| Policy Reference | Data Collection |</p>
<table>
<thead>
<tr>
<th>Number</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>What caregiver information and/or services have you received from the AAA?</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Do you feel the information/services provided were:</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Do you have any concerns about the information/services received?</td>
</tr>
</tbody>
</table>
| 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 |

<table>
<thead>
<tr>
<th>Number</th>
<th>8</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question</td>
<td>Do you believe the information/services provided has helped you and the person you provide care for remain independent at home?</td>
</tr>
</tbody>
</table>
| Measures | (1) Yes  
(2) No  
(7) Unsure/Doesn’t want to answer  
(9) Not applicable (doesn’t remember contact) |
<p>| Policy Reference(s) | Data Collection |</p>
<table>
<thead>
<tr>
<th>Number</th>
<th>Question</th>
<th>Measures</th>
<th>Policy Reference(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>Would you recommend these services to a friend or relative?</td>
<td>(1) Yes</td>
<td>Data Collection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Unsure/Doesn’t want to answer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9) Not applicable (doesn’t remember contact)</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>If you had a complaint about the customer service you received from the AAA, how would you handle it or who would you contact?</td>
<td>(1) Staff supervisor</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) Head of agency</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(3) Discuss with person involved</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(4) Not do anything</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(5) Not have contact with agency again</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Other ______________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Unsure/Doesn’t want to answer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9) Not applicable (doesn’t remember contact)</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you feel safe at home?</td>
<td>(1) Yes</td>
<td>Data Collection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) No, Explain ________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Unsure/Doesn’t want to answer</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you have any suggestions for or comments about the Caregiver Program?</td>
<td>(1) Yes, Explain ________________________________________________________________________</td>
<td>Data Collection</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(2) No</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Unsure/Doesn’t want to answer</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9) Not applicable (doesn’t remember contact)</td>
<td></td>
</tr>
<tr>
<td>Number</td>
<td>Question</td>
<td>Measures</td>
<td>Policy Reference(s)</td>
</tr>
<tr>
<td>--------</td>
<td>----------</td>
<td>----------</td>
<td>---------------------</td>
</tr>
<tr>
<td>13</td>
<td>What item was purchased for you?</td>
<td><strong>ASK ONLY OF THOSE ON THE FLEX SERVICE LIST</strong>&lt;br&gt; (1) List item____________________________________&lt;br&gt; (7) Unsure/Doesn’t want to answer&lt;br&gt; (9) Not applicable (doesn’t recall item being purchased)</td>
<td>Data Collection</td>
</tr>
<tr>
<td>14</td>
<td>How did this item help you?</td>
<td><strong>ASK ONLY OF THOSE ON THE FLEX SERVICE LIST</strong>&lt;br&gt; (1) Remain independent in the home&lt;br&gt; (2) Relief for caregiver&lt;br&gt; (3) Assistance with grandchildren&lt;br&gt; (4) Other, __________________________&lt;br&gt; (7) Unsure/Doesn’t want to answer&lt;br&gt; (9) Not applicable</td>
<td>Data Collection</td>
</tr>
<tr>
<td>15</td>
<td>If this item had not been purchased for you thru the AAA, how would you have managed without it?</td>
<td><strong>ASK ONLY OF THOSE ON THE FLEX SERVICE LIST</strong>&lt;br&gt; (1) Family would have purchased item.&lt;br&gt; (2) Church or other charitable organization would have purchased item.&lt;br&gt; (3) Would have done without.&lt;br&gt; (7) Unsure/Doesn’t want to answer</td>
<td>Data Collection</td>
</tr>
<tr>
<td>16</td>
<td>If you had not been able to secure this item, how would it have affected your everyday life?</td>
<td><strong>ASK ONLY OF THOSE ON THE FLEX SERVICE LIST</strong>&lt;br&gt; (1) No impact&lt;br&gt; (2) Decreased quality of life&lt;br&gt; (3) Health impact&lt;br&gt; (4) Safety in the home&lt;br&gt; (5) Other __________________________________________&lt;br&gt; (7) Unsure/Doesn’t want to answer</td>
<td>Data Collection</td>
</tr>
</tbody>
</table>
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?

| ☐ In person consultation/meeting(s) | ☐ Phone consultation |
| ☐ Information/assistance/referral to resources and services | ☐ Financial assistance/subsidy toward i.e. adaptive equipment, assistive technology |
| ☐ Caregiver education/training | ☐ Support group |
| ☐ Respite – a break from caregiving | ☐ 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:

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

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: ____________________________