



Date of Survey: _____

CONSUMER SATISFACTION SURVEY

1. Gender Male Female Transgender
2. Racial/ethnic background White (non-Hispanic) Black/African American Hispanic
 Asian / Pacific Islander Native American Other
3. Age 0-19 20-29 30-39 40-49 50 +
4. Number in household _____
5. Number of children in home (under 18) _____
6. County of residence _____

7. How long have you been a client of the agency?
 Less than 6 months 6 months to 1 year 1 to 3 years 3-5 years 5+ years
8. Have you used STAP's Case Management Services in the past year? Yes If "YES", go to question #9 No If "NO", go to question #15.

CASE MANAGEMENT

(Please complete only if you have received case management services in the past year.)

- | | All of the time | Most of the time | Some of the time | Never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 9. Do you believe that your HIV and medical information is kept confidential among the case management team unless otherwise authorized by a signed release? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Does your case manager help you understand and access available community resources? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Does your case manager treat you and your family with respect and dignity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Does your case manager encourage you to make your own choices about your services? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. As a result of receiving services, do you:

- | | More Often | Less Often | No Change | Does not apply |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| • Keep your medical appointments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Use Mental Health services as recommended | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Get better care from other agencies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Keep your drug/alcohol program appointments | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Take better care of yourself | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Manage crisis situations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Practice harm reduction in drug use (eg. using a new sterile needle with each injection, not sharing needles, reducing or eliminating overall drug use, changing from injection to snorting) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Need to use emergency rooms less frequently | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Know where you can go to get the services you need | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • Feel you have accessed the financial resources you are entitled to? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

14. How often do you see your case manager? (**check one**)
 less than once per month _____ ; once per month _____ ; twice per month _____ ; three times month or more _____

15. Have you used STAP's Medical Advocacy Services in the past year? Yes If "YES", go to question #16, No If "NO", go to question #31.

MEDICAL ADVOCACY

(Please complete only if you have met with a Medical Advocate in the past year.)

- | | All of
the
time | Most of
the time | Some of
the time | Never |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 16. Do you believe that your HIV and medical information is kept confidential among the Medical Advocates and client services staff unless otherwise authorized by a signed release? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Does the Medical Advocate <u>listen</u> to what you say and educate you about how to discuss your concerns with your doctor? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Does the Medical Advocate help you understand information about HIV/AIDS, Hepatitis C or other medical conditions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Does the Medical Advocate discuss with you the importance of consistently taking your prescribed medications? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Does the Program staff treat you and your family with respect and dignity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Does the Medical Advocate encourage you to make your own choices about your treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Have you used STAP's Housing Services in the past year? Yes <input type="checkbox"/> If "YES", go to question #23. No <input type="checkbox"/> If "NO", go to question #29 | | | | |

HOUSING

(Please complete only if you received Housing Services in the past year.)

- | | All of
the
time | Most of
the time | Some of
the time | Never |
|--|--|--|--|--------------------------|
| 23. Do you believe that your HIV status is kept confidential by the Housing Specialists and client services staff unless otherwise authorized by a signed release? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Is the staff accessible (Do they return phone calls in a timely manner, keep deadlines, deliver services as described?) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Does the Housing Program staff treat you and your family with respect and dignity? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Does the Housing staff encourage you to make your own choices about your housing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Do you find the information and services provided by the Housing staff helpful in stabilizing your housing situation? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Please check ALL Housing services you have used in the past year: | | | | |
| <input type="checkbox"/> Weatherization Supplies | <input type="checkbox"/> Minor Renovations for Handicap Access | <input type="checkbox"/> Housing Placement | <input type="checkbox"/> Money Management | |
| <input type="checkbox"/> HOPWA | <input type="checkbox"/> Moving Assistance | <input type="checkbox"/> Start-up Kit | <input type="checkbox"/> Temporary Storage | |

OTHER:

29. What could STAP do to improve case management, medical advocacy and/or housing services to STAP clients?

30. If needed, you may provide additional comments below:

Client Name (Printed): _____

Client Signature: _____