

Central Indiana First Steps
Six Month Review Survey

Please take a few minutes to provide feedback about your experiences in First Steps. This information will help us to better serve your needs and improve services for other children and families. This information is confidential.

We have provided a stamped/addressed envelope for the return of this survey.

Age of your child? _____ Your zip code? _____ Service Coordinator (optional) _____

Please respond to each statement using the following scale:

SA=Strongly Agree A=Agree D=Disagree SD=Strongly Disagree NA=Not Applicable

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|-----------------------------------------------------------------------------------------|----|---|---|----|----|
| 1. My six month review meeting was scheduled at a time/date convenient for my family. | SA | A | D | SD | NA |
| 2. My ongoing providers attended my six month review. | SA | A | D | SD | NA |
| 3. My child's services continued uninterrupted after the six month review meeting. | SA | A | D | SD | NA |
| 4. I have received cost participation statements regularly. | SA | A | D | SD | NA |
| 5. I understand my cost participation statements. | SA | A | D | SD | NA |
| 6. My Service Coordinator is responsive to my questions and concerns. | SA | A | D | SD | NA |
| 7. I am satisfied with my ongoing therapy providers. | SA | A | D | SD | NA |
| 8. I understand my rights and First Steps procedural safeguards. | SA | A | D | SD | NA |
| 9. I know who to contact if I have a concern about my providers or Service Coordinator. | SA | A | D | SD | NA |
| 10. First Steps is meeting the needs of my child and family. | SA | A | D | SD | NA |

Additional Comments or Feedback:

Please return this survey in the envelope provided. Your responses are confidential and will be used for program planning only. Thank you!