WESTBRIDGE CUSTOMER FEEDBACK SURVEY TOOL

30 Day   90 Day   180 Day   Subsequent Quarterly

NAME (Optional): ______________________________
PHONE NUMBER: ______________________________
DATE: ______________________________

On a scale of 1 (lowest) to 5 (highest), Please fill in the circle next to the appropriate score you would assign to each category. If the item is not applicable, please fill in the circle next to "N/A".

1. How satisfied have you been with:

Communication:	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5
Family Education and Support Program (FES):	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5
Care Management:	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5
Residential Care:	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5
Your progress or family member progress in Goal Attainment:	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5
Billing:	○ N/A	○ 1	○ 2	○ 3	○ 4	○ 5

2. Would you refer another family or participant to WestBridge for services?
   ○ Yes   ○ No
   Please Explain:
   ____
   ____
   ____

3. Would you refer another family or participant to WestBridge for services?
   ○ Yes   ○ No
   Please Explain:
   ____
   ____
   ____

4. May we use your comments for print/web/ad testimonials?
   ○ Yes   ○ No