CommUnity Care - David Powell Clinic **CLIENT SATISFACTION SURVEY**

Please tell us what you think of the services you have received from CommUnity Care - David Powell Clinic. Your responses are kept private. Thank you for your time and for sharing information with us.

Age:	**Sexual Orientation**	**How long have you been receiving services at CommUnity Care - David Powell Clinic**			
Gender:	**Straight _____ Gay _____**	**Less than 3 months**	_____	**1 year to 3 yrs**	_____
Home ZIP Code:	**Bisexual ____ Lesbian_____**	**3 months to 6 months**	_____	**3 years to 5 yrs**	_____
Race/Ethnicity:	**Other _____**	**6 months to 1 year**	_____	**More than 5 yrs**	_____

For each item mark one box.	**1 Very Satisfied**	**2 Satisfied**	**3 Not Satisfied Nor Dissatisfied**	**4 Dissatisfied**	**5 Very Dissatisfied**	**6 Does Not Apply**
I. Access to and Availability of Services	**1**	**2**	**3**	**4**	**5**	**6**
1. The location of CommUnity Care - David Powell Clinic.						
2. The times that services are available.						
3. The time it takes to get an appointment or get in touch with staff.						
4. The time I have to wait at CommUnity Care - David Powell Clinic to see staff.						
II. Customer Service/Staff Skills	**1**	**2**	**3**	**4**	**5**	**6**
5. I am treated with respect by staff (lifestyle, culture, religion, etc).						
6. I get services in a language that I understand.						
7. I understand the information given to me by staff.						
8. I handle my daily problems better because of services I get at CommUnity Care - David Powell Clinic.						
9. I am better able to manage my health because of services I get at CommUnity Care - David Powell Clinic.						
10. Staff responds to my needs and requests.						
11. Staff has offered me referrals to help me meet my needs. (Such as other programs, resources, agencies or specialists)						
12. Staff and I work together to plan my treatment and/ or services.						
III. Confidentiality	**YES**		**NO**			
13. My HIV and personal information is always kept private by staff and shared only when I give permission.	_____		_____			
IV. Transportation	**YES**		**NO**		**NOT APPLICABLE**	
14. I received information on transportation services when needed to attend my appointments (such as gas cards, cab vouchers, Metro Passes, STS, staff or agency vehicle).	**YES** _____		_____		_____	

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For each item mark one box.	1 Very Satisfied	2 Satisfied	3 Not Satisfied Nor Dissatisfied	4 Dissatisfied	5 Very Dissatisfied	6 Does Not Apply
V. The Quality of SERVICES I get from CommUnity Care - David Powell Clinic.	**1**	**2**	**3**	**4**	**5**	**6**
15.0 The quality of ALL services I get at CommUnity Care - David Powell Clinic						
15.5 The quality of Medical Care						
15.6 The quality of Behavioral Health Counseling (BHC)						
15.7 The quality of Pharmacy Services						
15.15 The quality of Psychiatric Services						
VI. Other services I get from THIS CommUnity Care - David Powell Clinic	**1**	**2**	**3**	**4**	**5**	**6**
16.1 The quality of All Other Services I get at CommUnity Care - David Powell Clinic						
16.13 The quality of Nutritionist (Dietitian) Services						
16.20 The quality of Social Work services						

COMMENTS (Please tell us more about answers where you marked Dissatifisfied or Very Dissatisfied):

VII. Grievance	**YES**		**NO**
17. I know how to make a complaint (Grievance Policy) about services with the CommUnity Care - David Powell Clinic.	_____		_____

VIII. Summary	**YES**		**NO**
18. I would recommend this CommUnity Care - David Powell Clinic to a friend or family member.	_____		_____

19. What do you like most about this CommUnity Care - David Powell Clinic?

20. What do you like least about this CommUnity Care - David Powell Clinic?