**CLAIMANT SATISFACTION SURVEY**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

We are interested in learning how satisfied you were with your experience at NYRC. Your opinion is important to us. In order to assist us in improving the care we provide to our claimants, please complete this *confidential* survey.

1. Were you aware of the reason for your referral prior to attending this facility? 🞎 Yes 🞎 No
2. How satisfied were you with the service (i.e., courtesy, respect, friendliness) you received today from:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Very****Satisfied** | **Satisfied** | **Dissatisfied** | **Very****dissatisfied** | **not applicable** |
| **Reception Staff** |  |  |  |  |  |
| **Assessor** |  |  |  |  |  |
| **Transportation (if provided)** |  |  |  |  |  |
| **Translation****(if provided)** |  |  |  |  |  |

1. Was your privacy respected in the clinic/office? 🞎 Yes 🞎 No
2. Was there adequate seating in the clinic? 🞎 Yes 🞎 No
3. Were the clinic and its facilities accessible? 🞎 Yes 🞎 No
4. Please share any suggestions that you feel could improve the accessibility of the clinic:

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1. How satisfied were you with the assessment?

 🞎 Very Satisfied 🞎 Satisfied 🞎 Dissatisfied 🞎 Very Dissatisfied 🞎 No Opinion

1. Overall, was your experience at the clinic?

 🞎 Excellent 🞎 Good 🞎 Fair 🞎 Poor

1. Please share any suggestions that you feel could improve the care we provide to our clients.

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***Thank you for completing this survey. Please leave form with receptionist.***