COOPERATIVE COUNSELING SERVICES
IIC CUSTOMER SATISFACTION SURVEY

Cooperative Counseling Services, LLC strives to provide evidenced–based treatment interventions in working with our youth and their families. To ensure effective services, we encourage our youth and families to provide us with feedback to highlight our strengths and identify where we might need improvement. Below are a series of statements on the quality of the services provided to your child and family. Please indicate your satisfaction by answering with "*Strongly Agree*," "*Agree*," "*Neutral*," "*Disagree*," or "*Strongly Disagree*." Your responses will be used for quality assurance purposes, supervision of staff and may be anonymously posted on our website in accordance with HIPAA.

We recommend that the survey be completed in pen (blue or black ink). Upon completion, you may place the survey in an envelope and initial the seal before returning it to your Clinician, Behavioral Assistant (BA), or Mentor. You may also mail this document directly to Cooperative Counseling Services at:

Cooperative Counseling Services
PO Box 1301
Mountainside, NJ 07092

Alternatively, you may complete this survey on our website: http://www.cooperativecs.com

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Child Name: _____

Parent/Guardian Name: _____

☐ *We wish to remain anonymous*

☐ *We do not want our responses anonymously shared on your website (HIPAA Compliant)*

How did your child enter services? ☐ Children's Mobile Response & Stabilization Services (CMRSS)

☐ Care Management Organization (CMO)

We are evaluating our: ☐ Clinician ☐ Behavioral Assistant (BA) ☐ Mentor

CCS Staff Member Name: _____

Satisfaction Survey	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
	5	4	3	2	1
1. **I was contacted by the Clinician/BA/Mentor within a week from the start of services to schedule the initial meeting.**					
2. **I was given a description of the services that were to be provided so that I had a full understanding of what the level of service entailed.**					
Satisfaction Survey	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**
	5	**4**	**3**	**2**	**1**
3. **I was involved in developing treatment goals for my child.**					
4. **I understood and agreed with the treatment goals set forth.**					
5. **I felt the treatment goals were effectively addressed throughout services.**					
6. **The services were consistent throughout the course of treatment on the part of the Clinician/BA/Mentor.**					
7. **In the case of tardiness or missed appointment, the Clinician/BA/Mentor notified me and made the effort to reschedule the appointment.**					
8. **In the event that the Clinician/BA/Mentor was unable to answer my call, my messages were returned within the week.**					
9. **I felt services effectively addressed any concerns that arose during the course of treatment.**					
10. **I felt that my child's services were provided in a manner that was sensitive to my culture/cultural background.**					
11. **I felt my child and I were treated with courtesy and respect at all times.**					
12. **I felt services were helpful to my child and/or family.**					

Please provide any additional feedback that you feel would be helpful for us to improve services:

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Thank you for taking the time to provide Cooperative Counseling Services, LLC with your feedback. Your input is valuable in providing us with the tools necessary to promote effective and high quality services for all our youths and families.