Long Term Home Health Care Program (LTHHCP)
AIDS Home Care Program (AHCP)

Consumer Satisfaction Survey

NAME:_____ CIN#: _____ DATE: _____
(Optional) (Optional) (Required)

Please complete the following if you are currently enrolled in the LTHHCP/AHCP waiver.

Your opinions are important to help improve the program. Responses to these questions will ***not*** *affect your ongoing participation in the LTHHCP or AHCP.*

Are you satisfied with the LTHHCP or AHCP overall?
Yes ☐ No ☐ N/A☐

Are you satisfied with the services you have received in the LTHHCP or AHCP?
Yes ☐ No ☐ N/A☐

Are you satisfied with the LTHHCP agency/staff?
Yes ☐ No ☐ N/A☐

Comments: _____

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Thank you for your assistance. You may request a copy of this survey for your records.