Consumer Satisfaction Survey

The New York Association on Independent Living (NYAIL), the NYS Office for People with Developmental Disabilities (OPWDD), in conjunction with the Department of Health (DOH), want to be sure that you received high quality, face-to-face services from a peer. To help us maintain and improve the quality of outreach services, we ask that you and your family take a few minutes to complete this survey and return it in the enclosed envelope. Your answers and opinions are very important to us and we thank you for taking the time to answer and return the survey.

Facility Name:	
Facility Type:	
Peer's Name	
Date of visit	

	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree	Not applicable
I liked the person I met with						
He/She gave me good information						
He/She listened to me						
I learned about things I can do in the community						
I feel better about my future						
I think my friends would like to meet with someone like I did.						
I will tell others about what I learned						
Today's meeting was excellent						

Would you like to request additional hours for this kind of peer support? You will be notified if additional hours are approved.

____ Yes ______ No

Do you want to meet with the same peer?

____ Yes ______ No

I would like to know more about:

Suggestions and comments: