TELESAGE™
The Wise Choice in Survey Systems

Agency ID: | | | **Clinic ID:** | | | | | |

Survey Completion Date: | | | / | | | / | | | | |
M M D D Y Y Y Y

Louisiana Quality of Care Survey - Parent

Will the parent take this survey?

1 ❑ Yes
2 ❑ Parent refused
3 ❑ Language barrier
4 ❑ Parent too impaired
5 ❑ Parent will not take survey for other reason

How long has your child been coming to this clinic?

1 ❑ This is his/her first visit
2 ❑ Less than 1 month
3 ❑ 1-2 months
4 ❑ 3-5 months
5 ❑ 6 months – 1 year
6 ❑ More than 1 year

What is your race? (Select all that apply.)

1 ❑ American Indian or Alaska Native
2 ❑ Asian
3 ❑ Black or African American
4 ❑ Native Hawaiian or Other Pacific Islander
5 ❑ White/Caucasian
6 ❑ Other/Not Available

Are you male or female?

1 ❑ Male
0 ❑ Female

What is your age group?

1 ❑ 18-25
2 ❑ 26-35
3 ❑ 36-45
4 ❑ 46-55
5 ❑ 56-64
6 ❑ 65+

What was the last grade you completed?

1 ❑ 1st 4 ❑ 4th 7 ❑ 7rd 10 ❑ 10th
2 ❑ 2nd 5 ❑ 5th 8 ❑ 8th 11 ❑ 11th
3 ❑ 3rd ` 6 ❑ 6th 9 ❑ 9th 12 ❑12th
13 ❑ Some College
14 ❑ College Graduate
15 ❑ GED
16 ❑ Special Education

Are either of the child's parents Hispanic or Latino?

1 ❑ Yes
0 ❑ No

Is your child male or female?

1 ❑ Male
0 ❑ Female

Does your child have Medicaid Insurance?

1 ❑ Yes
0 ❑ No

What is your child's race? (Select all that apply.)

1 ❑ American Indian or Alaska Native
2 ❑ Asian
3 ❑ Black or African American
4 ❑ Native Hawaiian or Other Pacific Islander
5 ❑ White/Caucasian
6 ❑ Other/Not Available

What is your child's age group?

1 ❑ 0-3
2 ❑ 4-6
3 ❑ 7-9
4 ❑ 10-12
5 ❑ 13-15
6 ❑ 16-18+

Please grade the quality of services you have been receiving using a grading scale similar to the one that teachers use in school.	***A*** **for Excellent**	***B*** **for Very Good**	***C*** **for OK**	***D*** **for Poor**	***F*** **for Failing**	**Not Applicable**
1. Overall, I am satisfied with the services my child received.	A	B	C	D	F	*
2. I helped to choose my child's services.	A	B	C	D	F	*
3. I helped to choose my child's treatment goals.	A	B	C	D	F	*
4. The people helping my child stuck with us no matter what.	A	B	C	D	F	*
5. I felt my child had someone to talk to when he/she was troubled.	A	B	C	D	F	*
6. I participated in my child's treatment.	A	B	C	D	F	*
7. The services that my child and/or family received were right for us.	A	B	C	D	F	*
8. The location of services was convenient for us.	A	B	C	D	F	*
9. Services were available at times that were convenient for us.	A	B	C	D	F	*
10. My family got the help we wanted for my child.	A	B	C	D	F	*
11. My family got as much help as we needed for my child.	A	B	C	D	F	*
12. Staff treated me with respect.	A	B	C	D	F	*
13. Staff respected my family's religious/spiritual beliefs.	A	B	C	D	F	*
14. Staff spoke with me in a way that I understand.	A	B	C	D	F	*
15. Staff were sensitive to my cultural/ethnic background.	A	B	C	D	F	*

As a result of the services my child and/or family received:	*A* for Excellent	*B* for Very Good	*C* for OK	*D* for Poor	*F* for Failing	Not Applicable
16. My child is better at handling daily life.	A	B	C	D	F	*
17. My child gets along better with family members.	A	B	C	D	F	*
18. My child gets along better with friends.	A	B	C	D	F	*
19. My child is doing better in school and/or work.	A	B	C	D	F	*
20. My child is better able to cope when things go wrong.	A	B	C	D	F	*
21. I am satisfied with our family life right now.	A	B	C	D	F	*
22. My child is better able to do things he/she wants to do.	A	B	C	D	F	*

The next two items you may answer with simply *Yes* or *No*

23. If your family could go anywhere you wanted for services, would you continue to come here?	Yes (1)	No (0)
24. Would you recommend the clinic to a friend or family member?	Yes (1)	No (0)

What do you and your child come here (go there) for? And how often?

Doctor visits/medication checks

1❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Group therapy-child focused

1 ❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Individual counseling

1 ❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Group therapy-parent focused

1 ❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Family therapy

1 ❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Other (for example, crisis services)

1 ❑ Once/week
2 ❑ Every 2 weeks
3 ❑ Once/month
4 ❑ Every 2 months
5 ❑ Every 3 months
6 ❑ Every 6 months
7 ❑ Every 6 weeks
8 ❑ Every 3 weeks
9 ❑ As needed

Please answer the following questions to let us know how your child is doing.

Is your child currently living with you?

1 ❑ Yes
0 ❑ No

Has your child lived in any of the following places in the last 6 months? (Select all that apply)

- ❑ With one or both parents
- ❑ With another family member
- ❑ Foster home
- ❑ Therapeutic foster home
- ❑ Crisis shelter
- ❑ Homeless shelter
- ❑ Group home
- ❑ Residential treatment center
- ❑ Hospital
- ❑ Local jail or detention facility
- ❑ State correctional facility
- ❑ Runaway/homeless/on the streets
- ❑ Other

The next four questions are about your child's medication.	***A*** **for Excellent**	***B*** **for Very Good**	***C*** **for OK**	***D*** **for Poor**	***F*** **for Failing**	**Not Applicable**
25. How would you grade how well your child's doctor informed you about what side effects to watch for?	A	B	C	D	F	*
26. How would you grade how well your child's doctor has responded to any medication side effects your child has experienced?	A	B	C	D	F	*
27. How would you grade how open your child's doctor is to questions about your child's medications?	A	B	C	D	F	*
28. How would you grade how well the medications have helped control symptoms or behavior that used to bother you or your child?	A	B	C	D	F	*

As a direct result of the services my child and/or family received: please answer for relationships with persons other than your mental health provider(s)	**Strongly Agree**	**Agree**	**I am Neutral**	**Disagree**	**Strongly Disagree**	**Not Applicable**
29. I know people who will listen and understand me when I need to talk.	1	2	3	4	5	*
30. I have people that I am comfortable talking with about my child's problems.	1	2	3	4	5	*
31. In a crisis, I would have the support I need from family and friends.	1	2	3	4	5	*
32. I have people with whom I can do enjoyable things.	1	2	3	4	5	*