

Targeted Case Management Program (TCM)
Screening, Assessment and Service Discharge Planning

- What services did you receive from the TCM Program?

Screening _____ Assessment _____ Discharge Planning _____

- If you requested screening services to see if you are eligible for services from the TCM, did you receive screening services within _____ days of your request?

- Were you satisfied with the TCM services you received?

Screening _____yes/no

Assessment _____yes/no

Discharge Planning _____yes/no

- Were you able to include others, such as family and friends in meetings with the TCM unit?

- Please check below if you were you informed about any of the following services:

- | | |
|---|--|
| • Nursing Facility waiver services? _____ | • Money Management? _____ |
| • MSSP? _____ | • Help with Meals? _____ |
| • Mental Health services? _____ | • Home Nursing? _____ |
| • On Lok? _____ | • Equipment (wheelchair, hospital bed, commode)? _____ |
| • IHSS? _____ | |
| • Case Management? _____ | |

- Were you informed about housing options? _____

- Were you asked where you would like to live? _____

- Were you asked what kind of supports you desire to live in the community?

- If you had a discharge planning meeting, did you feel comfortable with the actions taken after the meeting to help you with discharge? _____
- Were you told or given information about your appeal rights? _____

Please state any comments or concerns you may have about the TCM Program including any individual follow-up you need:

If you would like your name to be given to Protection and Advocacy, Inc. for information or assistance regarding follow-up, please print your name, sign and date below:

Print Name	Sign Name	Date
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Address

Phone Number(s)

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