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**Maryland Department of Health**

**Behavioral Health Administration**

**State Care Coordination Satisfaction Survey**

**Date:**

**State Care Coordinator (SCC) Name/Jurisdiction:**

For each statement listed below, please check the box that most closely describes your experience with our program.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Question** | **Verify Satisfied** | **Satisfied** | **Slightly Satisfied** | **Not Satisfied** | **Does Not Apply** |
| Were you satisfied that the SCC allowed you to choose your service provider(s) for services you were referred to? |  |  |  |  |  |
| How satisfied were you with the help you received from your SCC to get the resources you needed? |  |  |  |  |  |
| Were you satisfied with the way you were treated by your SCC? |  |  |  |  |  |
| How satisfied were you with the availability of your SCC? |  |  |  |  |  |
| How satisfied are you with the progress you are making in your Individualized Recovery Plan (IRP) goals toward your personal recovery? |  |  |  |  |  |
| Overall, how satisfied are you with the SCC services you received? |  |  |  |  |  |

**Please add any additional comments here:**