



Delaware Lifespan Respite Care Network Financial Assistance Evaluation Form

We are pleased to have provided you with respite care financial assistance in **2010**. Please take a few moments to complete this survey, **basing your responses on the service you received in 2010**. Your input is very important. It helps us stay responsive and assists in our efforts to continue to offer this service to Delawareans. Thank you for your time!

1. On a scale of 1 to 5, **with 5 being excellent**, please rate the following aspects of your experience with the Delaware Lifespan Respite Care Network Financial Assistance Program (circle your response):

	Poor	Fair	Good	V. Good	Excellent	N/A
A. Application process	1	2	3	4	5	N/A
B. Understandable procedures/forms	1	2	3	4	5	N/A
C. Promptness with payments	1	2	3	4	5	N/A
D. Ease of contact	1	2	3	4	5	N/A
E. Staff assistance/responsiveness	1	2	3	4	5	N/A
F. Overall rating	1	2	3	4	5	N/A

2. Did you use the money that you were awarded? All Some None

3. If you circle "NONE", why not?

4. Would you request funds from the Delaware Lifespan Respite Care Network in the future? Yes No

5. Would you recommend this program to others? Yes No

6. Were you able to use respite care because of this financial assistance? Yes No

7. What did you do during the respite time? (check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Spent time with spouse/significant other | <input type="checkbox"/> Personal time (rested, read a book, took a walk, etc.) |
| <input type="checkbox"/> Spent time with other family members | <input type="checkbox"/> Worked |
| <input type="checkbox"/> Spent time with friends | <input type="checkbox"/> Took a trip/vacation |
| <input type="checkbox"/> Did errands | <input type="checkbox"/> Attended a meeting/conference |
| <input type="checkbox"/> Did household chores | <input type="checkbox"/> Other (please specify): |

8. How refreshed and less stressed did your respite time make you feel?

Very Refreshed Somewhat Refreshed Not at All Refreshed
 5 4 3 2 1

9. How did you hear about the program? (check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Internet | <input type="checkbox"/> Flyer |
| <input type="checkbox"/> Service provider | <input type="checkbox"/> Word of mouth |
| <input type="checkbox"/> State agency | <input type="checkbox"/> Previous user |
| <input type="checkbox"/> Information table | <input type="checkbox"/> Other (please specify): |

10. Please describe how this service made a difference:

11. Do you have any other comments or suggestions?

12. Do we have your permission to use your comments in reports, publicity, website, etc.?

Yes – can use my name and my comments Yes – can use my comments anonymously No

If we have your permission to use your name, please fill out below:

Your name: _____ City: _____

**Please return completed survey to the Delaware Lifespan Respite Care Network,
using the enclosed self-addressed, stamped envelope.**

*If you have any questions about the Delaware Lifespan Respite Care Network's services,
please call 302-324-4444 ext. 2078 or e-mail caregiving@delrespice.org.*