MCCMH SUD QUARTERLY CLIENT SATISFACTION SURVEY REPORT

Provider Name:______________________________ License #/Location:_________________
Person completing form:__________________________________

	TIME PERIODS:	*DUE DATES:*
☐	**1st Quarter**	**January 15, 20__**
☐	**2nd Quarter**	**April 15, 20__**
☐	**3rd Quarter**	**July 15, 20__**
☐	**4th Quarter**	**October 15, 20__**

1. Consumer Satisfaction with Funded Services (if you did not conduct any consumer satisfaction surveys during this quarter, report zero).

*****Example: 15 clients surveyed, 10 clients responded to survey, of those 10 responders, 8 were satisfied***

Funded Substance Use Consumers	***Number Surveyed***	***Number Responded to Survey***	****NUMBER* of Responders Reporting Satisfied***
**Example:*	*15*	*10*	*8*
Persons 18 years and older			
Persons under 18 years			

2. Recipient Rights Complaints from Funded Consumers:

Number of Recipient Rights Complaints Submitted this Quarter	***Number of Recipient Rights Complaints Substantiated this Quarter***

3. The Number of Funded Substance Use Consumers Discharged with Reason being Death this Quarter?

4. The number of Outpatient and IOP (Block Grant, PA2, Medicaid, HMP) clients who **did not show** for services this quarter:

Number of Outpatient clients	***Number of IOP clients***