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Family/Supports Engagement Survey
2016-2017

CST would like to know what you think of the behavioral health services that your loved one is receiving. Please take just a few minutes to fill out and return this form

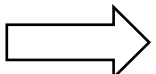
1. What is your zip code? _____

2. What types of service does your family member/loved one receive? (*Circle One*)
 - Adult Mental Health (MH)
 - Substance Use (SU)
 - Child/Adolescent Behavioral Health Services
 - Dual//Co-Occurring (MH/SU)

3. What is the name of the agency that provides your family member/loved one's services?

4. Do you feel that your loved one's service provider offers resources that empower and motivate your loved one to take responsibility for his/her own wellness? Yes _____ No _____
If so, please explain

5. What are some of the things that your loved one does in community to help him/her stay well?
Circle all that apply:
 - Church
 - Library
 - Community Center
 - Recreation Center (Playground)
 - School
 - Peer Support Meetings (AA/NA/CA)
 - Volunteer Work
 - Other _____

Over 

6. What resources do you feel are needed in your loved one's environment that will help improve their quality of life? (Circle what you feel is most needed)

- Housing
- Employment
- Education
- Access to medical care
- Access to nutritious food
- None
- Other _____

Please explain your response:

7. Does your loved one's behavioral health service provider offer resources to help your loved one obtain any of the following: (circle all that apply) Yes _____ No _____

- Housing
- Employment
- Education
- Access to medical care
- Access to nutritious food
- Community resources
- Social Activities
- Other _____

Please explain your response:

8. What information is needed in your community as a whole to help raise awareness and motivate people to improve their health and their environment?

8A. Where do you think this information should be made available in your community?

9. Who is paying for your loved one's treatment or living arrangement?
(Circle one):

- CBH (*Medicaid-Public Assistance*)
- Medicare and/or Private Insurance
- OMH (*Office of Mental Health*)
- BHSI (*no insurance for SU services*)

Optional: If you want CST to contact you, please provide:

Name:

Phone: