

Professional Provider Performance Evaluation and Survey

First Care Health Services, Inc. is pleased that your organization has utilized one of our agencies in the referral process for home care. In an effort to continue to develop our referral and care coordination processes, we would appreciate your feedback by completing the following survey. Please fax your completed survey to (434) 572-6211, Attn.: Lori Frazier, RN, Program Director. Thank you, in advance, for your time and comments.

Please indicate which agency/agencies you have utilized (current and previous utilization).

Commonwealth Home Health, Inc. First Dominion Home Health Care Personal HomeCare, Inc.

Please use a (√) to indicate your opinion of the following statements.

	Strongly Agree	Agree	Somewhat Agree	Disagree	Strongly Disagree
The referral process was completed with ease; information requested was pertinent to client care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When calling into the agency, you were greeted in a prompt and professional manner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Home care services were provided as requested.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequency of communications was appropriate and pertinent to the provision of client care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The agency provided opportunities for appropriate coordination of care among various disciplines.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your expectations for the home care client were met.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your client benefited from having home care.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grievances were resolved timely.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Commentary:

Would you request/recommend our agency to other clients/organizations to meet their needs? Yes
 No

Provider Name (optional): _____

Provider Representative (optional): _____

Telephone Number/Ext. (optional): _____