



Catholic Charities Caregivers Support Services
100 Slingerland Street. Albany, NY 12202
phone: (518) 449-2001 fax: (518) 426-3662

Elder Care client follow-up survey

County of Residence _____

Approximate Service Period _____ (Month(s))

Catholic Charities Caregivers is trying to gather feedback from families that have used our services this calendar year. We are in the process of calling caregivers to complete this survey by telephone. Thus, if you have already completed this survey over the phone, please do not fill it out now. We have created a 9 question survey to get some insight on the work that the Catholic Charities Caregivers program does. If you have a few minutes to complete this brief survey, it would help us greatly! Let us know how we're doing!

Most of these questions can be answered with a yes or a no; however, we can also take comments if you want to offer them.

1. Which of the following services did you or your loved one receive?

Respite (Home health aide, Day care, Adult Home, Assisted Living) Circle one

Counseling (Social Worker worked with you in a meeting face-to-face or by Telephone) Circle one

Support Group (Did you attend once Twice More than twice.) Circle one

2. If you received Respite services, do you feel that you, as a caregiver, experienced stress relief from your duties and role by the respite experience? Yes No Comments:

3. If you received respite services, did this respite time afford you the opportunity to think about future plans and/or assist in preparing for future needs? Yes No Comments:

4. If you received in home or telephone counseling was this helpful in increasing your feelings of support and resilience? Yes No Comments:

5. If you attended a support group, did it help you to feel less alone? Yes No
Did it give you support in any other way? Yes No
Comments:

6. Did you receive any information or assistance about other community services or resources - like EISEP or Lifeline? Yes No Comments:

7. Did the services you received help you maintain your own physical or emotional health? Yes No
Comments:

8. Did this service enable you to continue to care for your loved one at home? Yes No
Comments:

9. Do you believe that the services you received helped delay nursing home placement of your loved one?
Yes No Comments:

That is all we have for questions with this survey.
Thank you so much for your time.

Optional:

Name _____

Date _____

Would you like us to have a member of the staff give you a call for any questions or assistance in the future? Yes No Comments:

If yes, please supply a phone number: _____