



Division of Provider Services and Quality Assurance

Arkansas Lifespan Respite Voucher Program Satisfaction Survey

NOTICE: THIS FORM IS REQUIRED!

As part of the Arkansas Lifespan Respite Voucher Program, you are required to fill out this brief Satisfaction Survey and submit it to the Department of Human Services- Division of Provider Services & Quality Assurance. Failure to do so may result in the inability to participate in the voucher program in the future. Thank you.

Dear Family Caregiver:

Thank you for participating in the *Arkansas Lifespan Respite Voucher Program*. To assess how well the program worked for you, and to plan for future respite services, we ask that you complete the following short **Satisfaction Survey** and submit it to DHS-DPSQA **within 10 business days of the expiration of your award letter**. Your answers may help us in receiving funding in the future so that we can continue to offer financial assistance to Arkansans like you who need respite.

1. Did you use the respite voucher funding that you had originally requested on your *Arkansas Lifespan Respite Voucher Program Application Form*? (Please check one.) Yes- all of it Yes- partial No

a. If NO, what prevented you from using the respite services you had originally requested on your Application Form?

b. If YES-PARTIAL, what prevented you from using the remainder of the respite services?

c. What respite services, if any, did you use instead of the ones you had originally requested on your **Application Form**?

2. As a family caregiver, how useful was the Arkansas Lifespan Respite Program to you? (Please circle your response.)

- a. Very Useful b. Somewhat Useful c. Not Useful

Comments:

3. How easy was it to get financial assistance for respite services through the *Arkansas Lifespan Respite Voucher Program*? (Please circle your response.)

- a. Very Easy b. Somewhat Easy c. Difficult

Comments or Suggestions for Improvement:

4. What did the respite voucher funding provided through the *Arkansas Lifespan Respite Voucher Program* enable you to do? (Please check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Spend time with spouse/significant other | <input type="checkbox"/> Attend or participate in caregiver workshop/training or support group |
| <input type="checkbox"/> Spend time with other family members | <input type="checkbox"/> Participate in social/recreational activities
(i.e.: attend church, visit with friends) |
| <input type="checkbox"/> Run Errands | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Complete household tasks | _____ |
| <input type="checkbox"/> Have private time to relax, rest, read, pursue hobbies/interests | _____ |
| <input type="checkbox"/> Participate in physical activities or exercise | _____ |
| <input type="checkbox"/> Go to medical appointments | _____ |

5. Check the top three (3) challenges below that you have as a family caregiver.

- | | |
|--|---|
| <input type="checkbox"/> Financial (respite costs) | <input type="checkbox"/> Social isolation |
| <input type="checkbox"/> Feeling overwhelmed | <input type="checkbox"/> Strain on relationship with other family |
| <input type="checkbox"/> Physical, medical, or other health problems
(i.e.: headaches, back pain) | <input type="checkbox"/> No challenges |
| <input type="checkbox"/> Lack of sleep | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Depression, anxiety | _____ |

6. Check up to three (3) areas below that improved for you as a family caregiver due to respite services you received through this program.

- | | |
|--|--|
| <input type="checkbox"/> Financial relief (respite costs) | <input type="checkbox"/> Increased social activities |
| <input type="checkbox"/> Feeling less overwhelmed | <input type="checkbox"/> Enhanced relationship with other family members |
| <input type="checkbox"/> Reduction in physical, medical, or other health programs (i.e.: headaches, back pain) | <input type="checkbox"/> No improvement |
| <input type="checkbox"/> More sleep | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Decreased depression or anxiety | _____ |

7. As a family caregiver, if you could pick one respite service to help you in the future, what would it be and how would it help you?

Thank you for completing our survey! Please send this form to:

Department of Human Services
ATTN: Arkansas Lifespan Respite Program
PO Box 1437, Slot S428
Little Rock, AR 72203-1437

or

fax to (501) 682-8155; ATTN: AR Lifespan Respite Program

or

email to ARLifespan.Respite@dhs.arkansas.gov