

# Connections Case Management, LLC Survey



Thank you for your participation and feedback!

\* Required

1. My Case Manager is: \*

2. I am a: \*

- ☐ Individual
- ☐ Family member/ guardian
- ☐ Provider

3. My name is: (Optional)

4. Client HIPAA Name: (Optional)

5. Waiver: (Optional)

☐ FSW

☐ CIHW

6. Please rate your case manager's performance in the following areas: \*

	1- Very Poor	2- Poor	3- Neutral	4 - Good	5 - Very Good
Advocacy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Availability/Accessibility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Communication	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coordination of Supports/Services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ethical Behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Follow Through	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Knowledge of Available Resources	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Problem Solving Skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Quarterly Meeting Facilitation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Respects you and your concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. Additional Comments: (Optional)

8. Please let us know if you would appreciate a call from our management team.  
(Optional)

- ☐ Yes, please!
- ☐ No thank you.

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