

## Disaster Human Services Case Management – Survivor Satisfaction Survey

**PAPERWORK REDUCTION ACT OF 1995 (Pub. L. 104-13) STATEMENT OF PUBLIC BURDEN:** The purpose of this information collection is to enable ACF/OHSEPR to identify a disaster survivor’s unmet needs and provide case management support that can connect a disaster survivor to services that meet their needs. Public reporting burden for this collection of information is estimated to average 15 minutes per respondent, including the time for reviewing instructions, gathering and maintaining the data needed, and reviewing the collection of information. This is a voluntary collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information subject to the requirements of the Paperwork Reduction Act of 1995, unless it displays a currently valid OMB control number. The OMB # is XXXX-XXXX and the expiration date is XX/XX/20XX. If you have any comments on this collection of information, please contact the Office of Human Services Emergency Preparedness and Response, 330 C St. SW, Washington, D.C. 20201.

Thank you for participating in the Disaster Human Services Case Management Program. We would like to ask you a few questions about your experience. Your responses will help us improve the Program and support other disaster survivors like you. Participation in the survey is voluntary. Your answers will not negatively impact the services that you receive.

**Enter Name or Location of Disaster:**

**I received Disaster Human Services Case Management Services for:**

- 30 days or less                     
  31 – 60 days   
  61 – 90 days                     
  More than 90 days

**My case manager provided referrals for (select all that apply):**

- Behavioral Health                     
  Child Care                     
  Clothing                     
  Disability  
 Elder Care                     
  Employment                     
  Federal Disaster Assistance  
 Financial Assistance                     
  Food Assistance                     
  Health Insurance                     
  Housing – Short-term  
 Housing – Long-term                     
  Legal Services                     
  Medical                     
  Pharmacist  
 State human services                     
  Veteran assistance   
  Other \_\_\_\_\_

**Please describe your experience.**

	Strongly Agree	Agree	Neither Agree nor Disagree	Disagree	Strongly Disagree
1. My case manager treated me with respect	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. My case manager helped me identify my needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. My case manager actively involved me in the development of my case management plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. My case manager helped me find services I needed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My case management plan will help me recover from the disaster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you answered Disagree or Strongly Disagree to the questions above, please explain why:**

Thank you very much for your time and cooperation. Your responses have been very helpful to us.