

**Caregivers Ministry Network (CMN)
Caregiver Satisfaction Survey**

Last Name: _____ First Name: _____

Please answer the following questions about yourself:

Age: under 20 20-30 31-40 41-50 51-60
 61-70 71-80 81-90 90+

Gender: Male Female

Race/Ethnicity: Black/African American White/Caucasian
 Native American Asian/pacific Islander
 Hispanic/Latino Other _____

Are you currently employed outside of the home?

Yes No

If yes, how many hours per week do you work?

Less than 10 10-20 20-30 30-40 over 40

How satisfied are you with the over all services of Caregivers Ministry Network?

Very Satisfied Somewhat Satisfied Not Satisfied

Which services does Caregivers Ministry Network assist you with?

(Please circle all that apply)

Information and Referral

Transportation

Personal care

Chores

Errands

Respite

Other _____

Other _____

**Please answer the following questions concerning your Caregivers
Ministry Network service provider:**

My CMN service provider is on time.

Strongly Agree Agree Disagree Strongly Disagree

My CMN service provider has a positive attitude.

Strongly Agree Agree Disagree Strongly Disagree

The services my CMN service provider supplies are helpful to me.

Strongly Agree Agree Disagree Strongly Disagree

My CMN service provider completes tasks well.

Strongly Agree Agree Disagree Strongly Disagree

My CMN service provider is willing to do extra tasks when needed.

Strongly Agree Agree Disagree Strongly Disagree

My CMN service provider's hours are sufficient to meet my needs.

Strongly Agree Agree Disagree Strongly Disagree

Please answer the following questions about your loved one:

Age: under 20 20-30 31-40 41-50 51-60

61-70 71-80 81-90 90+

Gender: Male Female

Race/Ethnicity: Black/African American White/Caucasian
 Native American Asian/pacific Islander
 Hispanic/Latino Other_____

What is your loved one's current medical condition?

(Please circle all that apply)

High Blood Pressure Diabetic Alzheimer's Cancer
 Depression Stroke Heart Other_____

What is your loved one's current functional status?

(Please circle all that apply)

Ambulatory shortness of breath
 Incontinence: Bowel Bladder
 Impairment: Speech Vision Hearing
 Other_____

Please include any additional comments you would like to make:

**Return completed surveys to the CMN office at
Corinthian Baptist Church
1725 Caniff
Hamtramck, MI 48212**

Thank you!