



**PENN Behavioral Health
Work-Life Services
INDIVIDUAL CLIENT SATISFACTION SURVEY**

Company Name:	Date:
Location:	
Client Name (Optional):	Department Name (Optional):

PENN Behavioral Health is committed to improving the quality of services we deliver to our individual clients. Please assist us in our efforts by answering some questions about our work-life services. Your responses will help us to identify and meet your expectations. Thank you for your cooperation. Please check the box next to your response. **Upon completion of the survey, please submit via fax at 215-746-7454, or by mail to PENN Behavioral Health Corporate Services, 3535 Market Street 4th Floor, Philadelphia, PA 19104.**

Section A

1. Did the services you received through Penn Behavioral Health help you resolve your work-life issue? Yes
 No
2. Did our intake counselor and the work-life consultant provide you with supportive resources such as pertinent topic information and outside resources? Yes
 No

If you answered no to Question 1 please answer 3a, 4a, and 5a and skip to Section D:

- 3a. Were there additional factors that prevented you from resolving your problem? Yes
 No

4a. If yes, what were the factors? _____

- 5a. Can we offer you additional services? Yes
 No

If you answered yes to Question 1, please answer Section B:

Section B

	Excellent	Very Good	Fair	Poor	N/A
3b. Please rate the timeliness of our intake counselor's response:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4b. Please rate the warm transfer from our intake counselor to the work-life consultant:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5b. Please rate the professionalism of the work-life consultant:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6b. Please rate the timeliness of the service:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7b. Please rate the work-life consultant's understanding of the problem:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8b. Please rate the quality of the work-life resources in relation to your issue:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered yes to Question 1, please answer Section C:

Section C

- | | Significantly | Mildly | Not Significantly | N/A |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 9c. Did the services you received from us help you resolve a work-life issue? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10c. Did the services you received from us help you resolve any workplace issues? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11c. Did the services you received from us help you improve your ability to cope? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12c. If you answered “not significantly” to any of the above questions, can we help you further in any way? | | | <input type="checkbox"/> | Yes |
| | | | <input type="checkbox"/> | No |
-

*All survey participants please complete Section D.
Remember that this information is completely confidential.*

Section D

- 13d. At the time you requested services from us, did the issue cause you to be absent from work? Yes
 No
- If yes, how often in the most recent three month period:
- Less than a day
 - 1 to 3 days
 - 3 to 5 days
 - More than 5 days
- Please rate the timeliness of our intake counselor’s response:
- Not at all
 - Less than a day
 - 1 to 3 days
 - 3 to 5 days
 - More than 5 days
- 14d. At the time you requested services from us, did the issue cause you to be late for work? Yes
 No
- If yes, how often in the most recent three month period:
- 1 to 3 times
 - 3 to 5 times
 - 5 to 7 times
 - 7 to 10 times
 - More than 10 times
- After receiving services from us, how often did the issue cause you to be late for work?
- 1 to 3 times
 - 3 to 5 times
 - 5 to 7 times
 - 7 to 10 times
 - More than 10 times
- 15d. At the time you received services from us, did you ever feel the problem might cause you to leave your employment? Yes
 No
- If yes, did the services we provided help you maintain your employment?
- Significantly
 - Mildly
 - Not significantly
 - N/A
-

16d. In the 3 months prior to receiving services from us, was your health being affected by your problem? Yes
 No

If yes, do you feel healthier now? Yes

No

If "no" is there some way we can further help you? Yes

No

17d. Would you contact the EAP in the future if you had a problem? Yes
 No

If "no" why not? _____

COMMENTS

*We would like to thank you for your time and help in improving the services provided by
PENN Behavioral Health Work-Life Services Program.*