SURVEY ID # _____

MISSOURI DEPARTMENT OF ELEMENTARY AND SECONDARY EDUCATION
OFFICE OF CHILDHOOD — HOME VISITING

CLIENT SATISFACTION SURVEY

INSTRUCTIONS

The Missouri Department of Elementary and Secondary Education (DESE) supports a number of home visiting programs throughout the state. Each year DESE conducts a client satisfaction survey among the families in these programs. The information gathered from participants helps to improve the home visiting program. The results of the survey will be shared with the supervisor of your local home visiting agency.

Please complete the survey below and return it sealed in the envelope provided to your home visitor.

Date: _____

Name of Home Visitor (Optional): _____

QUESTIONS: Contact the Office of Childhood — Home Visiting at 573-522-2355 or homevisiting@dese.mo.gov.

Home Visitor: Mail the completed form by 02/28/2023 to Missouri Department of Elementary and Secondary Education, Office of Childhood, P.O. Box 480, Jefferson City, MO 65102.

PROGRAM

Check the box of the program in which you are enrolled.

- ☐ Columbia-Boone County Department of Public Health and Human Services (Boone County) — Healthy Families America
- ☐ South Central Missouri Community Action Agency (SCMCAA) (Butler and Ripley Counties) — Early Head Start Home-Based Option
- ☐ Great Circle Southeast (Mississippi and New Madrid Counties) — Healthy Families America
- ☐ Kansas City Health Department (Cass, Clay, Jackson, Johnson, Lafayette, Platte, and Ray Counties) — Nurse Family Partnership
- ☐ Malden R-1 School District (Dunklin County) — Parents as Teachers
- ☐ Phelps/Maries County Health Department (Phelps and Maries Counties) — Healthy Families America
- ☐ Randolph County Health Department (Randolph County) — Healthy Families America
- ☐ Southeast Hospital (Bollinger, Cape Girardeau, Mississippi, New Madrid, Perry, Scott, Ste. Genevieve, and Stoddard Counties) — Nurse Family Partnership
- ☐ St. Louis County Department of Public Health (St. Louis City and St. Louis County) — Nurse Family Partnership
- ☐ Parents as Teachers National Center (St. Louis City) — Parents as Teachers

CHILD/FAMILY INFORMATION

Please check if you are pregnant, AND enter the number of child(ren) you have within each age group.

- ☐ Pregnant
- ☐ 0 – 12 Months
- ☐ 1 – 3 Years
- ☐ 4 – 5 Years

How long have you been enrolled in this program? (You may estimate).

- ☐ 0 – 6 Months
- ☐ 7 – 12 Months
- ☐ More than 1 Year
- ☐ More than 2 Years
- ☐ I am no longer enrolled

What is your ethnicity?

- ☐ Hispanic or Latino
- ☐ Non-Hispanic or Latino

What is your race?

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or other Pacific Islander
- ☐ White
- ☐ Multiple Races
- ☐ Other

What is your level of education?

- ☐ Less than a high school diploma
- ☐ High school diploma or GED
- ☐ Some college
- ☐ College degree

What is your age?

- ☐ Under 15 Years
- ☐ 15 – 17 Years
- ☐ 18 – 19 Years
- ☐ 20 – 24 Years
- ☐ 25 – 29 Years
- ☐ 30 – 34 Years
- ☐ 35 – 39 Years
- ☐ 40 – 44 Years
- ☐ 45+ Years

HOME VISITOR INFORMATION

Check ALL of the features that describe your home visitor.

☐ Understanding	☐ Good listener	☐ Doesn't listen
☐ Organized	☐ Unorganized	☐ Encouraging
☐ Educated	☐ On time	☐ Not on time
☐ Caring	☐ Available	☐ Unavailable
☐ Truthful	☐ Dishonest	☐ Rude

HOME VISITOR INFORMATION

How often does your home visitor talk with you about the following subjects? Select ONE answer following each statement.	OFTEN	SOMETIMES	NEVER
1. Your child's/children's development	☐	☐	☐
2. Parenting your child/children	☐	☐	☐
3. Your child's/children's health	☐	☐	☐
4. Your child's/children's immunizations/shots	☐	☐	☐
5. The importance of well-child checkups	☐	☐	☐
6. Your health	☐	☐	☐
7. Safe sleep	☐	☐	☐
8. Child safety	☐	☐	☐
9. Completing or advancing your education	☐	☐	☐
10. Getting a job/employment	☐	☐	☐

LEVEL OF POSITIVE CHANGE

Select the level of positive change* you have experienced because of your participation in this program. *A positive change can be anything that has improved your life or your family's life.	LARGE CHANGE	MEDIUM CHANGE	SMALL CHANGE	NO CHANGE	CHANGE WAS NOT NEEDED
1. My ability to solve problems	☐	☐	☐	☐	☐
2. My ability to cope with problems/stress	☐	☐	☐	☐	☐
3. My happiness	☐	☐	☐	☐	☐
4. My relationship with my partner/spouse or the other parent of my child(ren)	☐	☐	☐	☐	☐
5. My ability to care for my child(ren)	☐	☐	☐	☐	☐
6. My living situation	☐	☐	☐	☐	☐
7. My ability to control my temper	☐	☐	☐	☐	☐
8. My understanding about warning signs of potential child abuse/neglect (e.g., anger, depression, self-esteem)	☐	☐	☐	☐	☐
9. My understanding of my child's/children's development	☐	☐	☐	☐	☐
10. My understanding of what my child(ren) need(s) from me as the parent	☐	☐	☐	☐	☐
11. My ability to take care of the health care needs of my family	☐	☐	☐	☐	☐

PROGRAM INFORMATION

How would you describe the quality of services you received from the program?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Was there any information or services that you needed and did not receive?

- ☐ Yes
- ☐ No

If yes, please explain here:

_____

_____

What one thing would you like changed about the program and why?

_____

_____

Would you like to keep the option of having virtual visits with your home visitor if needed?

- ☐ Yes
- ☐ No

If yes, please explain here:

_____

_____

Are you likely to recommend this program to others?

- ☐ Yes, definitely
- ☐ Yes, probably
- ☐ No, probably not
- ☐ No, definitely not

Thank you for taking the time to complete this very important client satisfaction survey. The information you have provided will help us to improve the program.