Consumer/Family Satisfaction Team of Beaver County (C/FST)
139 Brighton Ave.
Rochester, PA 15074
Phone: (724) 775-7650
Fax: (724) 775-0266

The Consumer Family Satisfaction Team reports the satisfaction of consumers/families who use behavioral health (mental health and or drug and alcohol services) in the county. Our goal is to determine **your satisfaction** with the services you receive and work with Beaver County Behavioral Health in the planning and improvement of behavioral health services.

We would like to talk to adults/parents/children about any or all the behavioral services received in the **past 6 months**. The results of the survey used only to improve behavioral health services.

Please complete the form below and return/fax to the above address **OR** you are welcome to call the telephone number above and leave a message. Someone will return your call within a few days. If the survey is in regard to your child, and he/she is 14 years of age or older, we hope to ask him/her to complete a survey separately, with your permission. All surveys are **Confidential**. **THERE ARE NO NAMES, DATES OF BIRTH, or PHONE NUMBERS RECORDED ON YOUR SURVEY.**

Anyone completing a survey will be entered in a drawing for a chance to win a $10 card.

____ I would like to participate in a telephone survey. The best time for the C/FST to call you is _____ AM/PM

____ I give permission for C/FST to leave a voicemail regarding this release form and the survey.

Please check the mental health services that you (and/or your child) have used IN THE LAST 6 MONTHS.

ADULT MENTAL HEALTH SERVICES

____Case Management
____ Community Residential Rehabilitation (**CRR**)
____ Drop-in Center (**Phoenix Center**)
____Dual Diagnosis Treatment Team (DDTT)
____Emergency/Crisis
____ Forensic-Assertive Community Treatment (F-**ACT**)
____ Friday Night Friends
____ Friendship Room
____ Inpatient
____ Long Term Structured Residence (**LTSR**)
____ Outpatient Treatment
____Personal Care Resocialization Program
____Psychiatric Rehabilitation (**Aurora Program**)
Peer Support, MHA
___ Reentry Program
____Representative Payee
____Vocational Rehabilitation (**BCRC**)
____ Warm Line
___ WIN (Working with Individual Needs)

ADULT DRUG & ALCOHOL SERVICES

____ Methadone Clinic
____Outpatient Drug & Alcohol

CHILDREN'S MENTAL HEALTH SERVICES

____ Behavioral Health Rehabilitation Services **(BHRS) (Parent/Child)**
____Case Management **(Parent or Child)**
____Emergency/Crisis **(Parent or Child)**
____ Family Based Mental Health Services **(Parent/Child)**
____ HELP
____ Independent Evaluator
_____Emergency Crisis (**Parent or Child)**
____ Outpatient **(Parent / Child)**

Name (**Print)** _____ **Signature** _____

Child's Name/Age (If Applicable) _____ Phone number _____

Address _____ City/State/ Zip code _____