MAPS CLIENT SATISFACTION SURVEY

Please check the office where you received the services:

MAPS Office: Brighton ___
Cambridge ___
✓ **Dorchester ___**
Framingham ___
Lowell ___
Somerville ___

Date: __ /__/__
Age: _______Gender: ______ Male______ Female ______ Other
Country of origin:_______________________________________
City of residence: __________________________________ State:__________

How were you referred to MAPS?
____Radio__ __Newspaper/Magazine ____Website____Friend____Doctor____School____Other organization

Could you please rate the services that you received? Check off the box that best represents your opinion.

Front Desk/Reception Area	Excellent	Great	Good	Fair	Poor	No opinion
a. Professionalism						
b. Knowledge of Agency Services						
c. Knowledge of Program						
d. Awareness of Community Services						
Overall **SATISFACTION**						

Service/Program:_______________	Excellent	Great	Good	Fair	Poor	No opinion
Name of Staff Person:____________						
a. Professionalism						
b. Knowledge of Agency Services						
c. Knowledge of Program						
d. Awareness of Community Services						
Overall **SATISFACTION**						

What type of assistance were you seeking?____
____
Was your problem solved?____
____
Suggestions for better service or other comments:___________________________________
____
Would you return to MAPS for other services?_______________________________________
____
Are you a member of MAPS?______________________________ If not, would you consider becoming a member?____
____

Thank you for taking the time to fill out the survey