Department of Children and Families
Customer/Companion Feedback Form

(To be completed by clients/customers who are Deaf or Hard-of-Hearing Only)

The Department of Children and Families is committed to providing excellent customer service. We value your opinion and request that you complete this short survey to assist us in evaluating and improving our services. While you are not required to respond, we thank you in advance for completing this survey**. The survey is ANONYMOUS; therefore, please do not provide your name or any other personal information UNLESS YOU WOULD LIKE TO BE CONTACTED**. Please complete the form and **submit it to the local office or mail to**: Department of Children and Families, Office of Civil Rights, 1317 Winewood Boulevard, Building 1, Room 110, Tallahassee, Florida 32399-0700.

IF YOU NEED ASSISTANCE IN COMPLETING THIS FORM PLEASE NOTIFY STAFF OR CONTACT THE OFFICE OF CIVIL RIGHTS AT (850) 487-1901 OR TDD (850) 922-9220

Please provide a response to the following:

1	Are you a: Client/Customer ☐ Companion ☐ who is deaf or hard-of-hearing?
2	Were you provided any assistive services and technologies? (Please check all that were provided.) ☐ Certified Interpreter ☐ Qualified Staff ☐ VRS ☐ Pocket Talker ☐ Motiva ☐ CART ☐ Other: _____
3	Were the assistive services and technologies effective? ☐ Yes ☐ No (If no, please explain.)
4	Were you denied assistive services and technologies? ☐ Yes (If yes, please complete #5) ☐ No a. What was requested? _____ b. What was provided? _____
5	If you answered yes to #4, please provide the reason you were given for denial of the requested assistive services and technologies?
6	Did you agree with the agency's decision given for the denial of the requested assistive services and technologies? If no, why?
7	The request for assistive services and technologies was made: ☐ Before the Appointment ☐ Onsite
8	Provide date(s) assistive services and technologies were requested and provided. a. My request for assistive services and technologies was made to the agency on: _____ (MM/DD/YYYY) b. Date assistive services and technologies were provided by the agency: _____ (MM/DD/YYYY)
9	Were the assistive services and technologies provided within two hours of your request? ☐ Yes ☐ No

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	If no, what was the timeframe after the request was made? _____
10	Were you aware or informed that all assistive services and technologies were at no cost to you? ☐ Yes ☐ No
11	At what DCF location or Contract Agency did you receive services?
12	Were services provided to you in a fair manner? ☐ Yes ☐ No a)If no, please explain. b)Do you feel you were discriminated against? If so, please provide your contact information. (This is optional)
13	Did staff treat you with respect? ☐ Yes ☐ No If no, please explain.
14	What assistance did you receive in completing this form, if any?
15	Additional Comments:

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