Virginia Reuse Network Data Collection Tool

This survey is for persons who have received assistive technology (AT) device(s) from our device reuse network and must be filled out by the Customer or a Designee. Use back for comments.

Customer Name: _____ Phone: _____

Where did you get the AT device: _____

AT device(s) received: _____

Date equipment received/service delivery was completed: _____

Date this form was received/returned by Customer: _____

☐ Are you (or the person you represent) currently a Client of the Department of Rehabilitative Services (DRS)? If so, who is your counselor: _____

☐ Do you (or the person you represent) have a traumatic spinal cord injury?

☐ Do you (or the person you represent) have a traumatic brain injury?

☐ Are you (or the person you represent) a Veteran?

The primary purpose for which I need (or the person I represent needs) an AT device or service is related to: **(CHECK ONE)**

- ☐ Education
- ☐ Community Living
- ☐ Employment

Why did you choose to obtain an AT device/service from our program? **(CHECK ONE)**

- ☐ I could only **afford** the AT though this program. (I could not afford it through other programs.)
- ☐ The AT was only **available** to me through this program. (I am not eligible or don't qualify for other programs, the AT is not covered by other funding sources or the specific device I needed is not provided by other programs.)
- ☐ The AT was available to me through other programs, but the system was **too complex** or the wait time was too long.
- ☐ None of the above

Which of the following best reflects your level of Satisfaction with the services you received? **(CHECK ONE)**

- ☐ Highly satisfied
- ☐ Satisfied
- ☐ Satisfied somewhat
- ☐ Not at all satisfied

Completed by: _____ Date: _____