**New York State Center for Independent Living (CIL) 2025 Consumer Satisfaction Survey**

This survey gives you a chance to say what you think about services you received at your local Independent Living Center. Results will help centers understand areas of strength and needed improvement. This accessible version is for those who have difficulty navigating an online survey.

Please underline, **bold, or** highlight your responses to each question. Toward the end of the survey, there is a place for you to enter comments if you wish. If you are taking the survey on behalf of another person, please select their answers, not your own. All answers and comments are anonymous. When you are done, please email it back to the person who sent it to you. Thank you for your help in making your center the best it can be!

**Question #1 What Independent Living Center did you receive services from during the past year?**

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**Question #2 The staff and I were able to communicate about my needs easily and clearly.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 3: The staff was ready to work with me to solve problems.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question #4: The staff treated me respectfully.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 5: In most cases, the staff responded back to me in a timely manner.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 6: The staff helped me develop a plan to meet my goals.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 7: I was able to make decisions about the services I received.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 8: The staff helped me understand the choices and services available to me.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree | N/A

**Question # 9: I am satisfied with the support and services I received.**

Strongly Agree | Agree | Neutral | Disagree | Strongly Disagree

**Question #10: Please provide any additional comments below:**

**Demographics (optional):** Please let us know about your background to help us better understand the people we serve.

**11. What is your gender? (Select one)**

Male

Female

Choose not to answer

Other (please self-identify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. What age group are you in? (Select one)**

Under 5

5-19 years

20-24 years

25-59 years

60-older

Unavailable

Choose not to answer

**13. What race do you identify with? (Select one)**

Asian

Black or African American

Caucasian/White

Native American

Native Hawaiian or Other Pacific Islander

Multiracial (Two or more races)

Unknown

Choose not to answer

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. What ethnicity do you identify with? (Select one)**

Hispanic

Latino

Not Hispanic/Latino

Choose not to answer

Other

**15. Which of these unserved/ underserved community groups do you identify with? (Select all that apply)**

Minorities with disabilities

LGBTQIA+ with disabilities

Veterans with disabilities

Youth/young adults with disabilities

Seniors with disabilities

Immigrants with disabilities

Deaf/blind individuals

Rural residents with disabilities

None of the above

Other (please identify below)

**16. What type of disability or disabilities do you experience? (Select all that apply from each category)**

* **Cognitive:**

Autism

Epilepsy

Intellectual Disability

Learning disability

Traumatic and other brain injuries

Other cognitive disabilities

* **Physical:**

Amputation

Back injury

Cerebral palsy

Environmental and other related illnesses

HIV/AIDS

Muscular dystrophy

Neuromuscular

Orthopedic

Spina bifida

Spinal cord injury

Other congenital birth anomaly

Other physical disabilities

* **Mental:**

Emotional/behavioral disability

Mental health diagnosis

Substance abuse

Other mental illness

* **Sensory:**

Blindness

Deaf/blind

Deafness

Hard of hearing

Low vision (partially sighted)

Other sensory disabilities

* **Other Disability** (please identify below)

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY