**Asthma Home Visit Program — Participant Survey**

Thank you for participating in the Asthma Home Visit Program. We hope it has been helpful. We hope you now have ideas about how to make changes in your home that can reduce you or your child’s asthma symptoms.

We would like to learn about your experience. We appreciate you providing honest answers to our questions. Your responses to the survey will be anonymous. No one will be able to connect your answers to you or your family. Nothing you share will affect whether you receive services in the future.

Please circle the answers below that best reflect your experience.

**How many asthma home visits did you have?**

|  |  |  |
| --- | --- | --- |
| One | Two | Three |

**Was the length of each home visit …**

|  |  |  |
| --- | --- | --- |
| Too long | About right | Too short |

**Was the length of time between each home visit …**

|  |  |  |
| --- | --- | --- |
| Too long | About right | Too short |

**Was the amount of information covered in each visit …**

|  |  |  |
| --- | --- | --- |
| Too much | About right | Too little |

**Was the number of visits so far …**

|  |  |  |
| --- | --- | --- |
| Too many | About right | Too few |

**Were the written materials you received during the home visit useful?**

|  |  |  |  |
| --- | --- | --- | --- |
| Completely useful | Very useful | Somewhat useful | Not at all useful |

**Were the written materials easy to understand?**

|  |  |  |  |
| --- | --- | --- | --- |
| Completely easy | Very easy | Somewhat easy | Not at all easy |

**Do you continue to refer to the materials you received?**

|  |  |  |  |
| --- | --- | --- | --- |
| All the time | Frequently | Occasionally | Never |

**How comfortable were you having the Asthma Home Visitor in your home?**

|  |  |  |  |
| --- | --- | --- | --- |
| Completely comfortable | Very comfortable | Somewhat comfortable | Not at all comfortable |

**Do you think you will share anything you learned with others?**

|  |  |  |  |
| --- | --- | --- | --- |
| Definitely | Probably | Probably not | Definitely not |

**How satisfied are you with services you’ve received from the Asthma Home Visiting Program?**

|  |  |  |  |
| --- | --- | --- | --- |
| Completely satisfied | Very satisfied | Somewhat satisfied | Not at all satisfied |

**Would you recommend this program to other people you know who have asthma?**

|  |  |  |  |
| --- | --- | --- | --- |
| Definitely | Probably | Probably not | Definitely not |

**How confident do you feel about managing your or your child’s asthma?**

|  |  |  |  |
| --- | --- | --- | --- |
| Completely confident | Very confident | Somewhat confident | Not at all confident |

**What else would you like to tell us about the Asthma Home Visit Program?**

**Thank you for taking the time to answer these questions.**

**Please use the envelope provided to mail this survey back to {ORGANIZATION}**

**by the date specified on the top of the front page. We appreciate it!**

If you have any questions about this survey, please contact

{NAME, EMAIL, PHONE NUMBER}