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| State_Seal3DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES (DCYF)  **Family Feedback Questionnaire** | | | | | |
| Please read the statements below about your experience with (DCYF) and the Family Team Decision Making (FTDM) meeting.  Check the box that best fits how you feel.  The information will be used to help Children’s Administration work with families in the future. | | | | | |
| OFFICE NAME | | | | | |
|  | STRONGLY AGREE | AGREE | DISAGREE | STRONGLY DISAGREE | NOT APPLICABLE |
| 1. The FTDM was facilitated in a manner that was genuine and respectful. |  |  |  |  |  |
| 1. The meeting process was explained clearly. |  |  |  |  | N/A |
| 1. I felt listened to, and my ideas and suggestions were used in developing plans for my family. |  |  |  |  |  |
| 1. I understand what I need to do to keep my child / children safe. |  |  |  |  | N/A |
| I would also like to say. . . | | | | | |