N.C. DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF SERVICES FOR THE BLIND
INDEPENDENT LIVING REHABILITATION

INDEPENDENT LIVING MINI CENTER SURVEY

Date: _____

Name: _____ **Age:** _____

County of Residence/Mini Center: _____

PRIOR to receiving services:

Please list three areas or activities limited by your visual loss and/or in which you feel you need assistance:

1. _____
2. _____
3. _____

AFTER receiving services:

Please tell us if you feel better about or more capable in the areas of concern that you mentioned above:

1.None ☐ **A Little** ☐ **A Good Bit** ☐ **A Lot** ☐

2.None ☐ **A Little** ☐ **A Good Bit** ☐ **A Lot** ☐

3.None ☐ **A Little** ☐ **A Good Bit** ☐ **A Lot** ☐

Please tell us which classes/activities have been/will be the most helpful to you:

INDEPENDENT LIVING MINI CENTER SURVEY

Please tell us which classes/activities you liked best:

Please make suggestions for further services needed and/or improvements in services delivered:

Cc: District/Regional Supervisor
IL Rehabilitation Program Specialist