STOPOVER, INC. **PARTICIPANT FEEDBACK FORM**

NAME:_____
CONTACT #:_____
STAFF SIGNATURE:_____

1. Are you living with your biological family and/or family of choice?
2. Do you feel safe at home or are you scared sometimes?
3. Do you ever still think of running away? If so, where do you go and what do you do?
4. Do you go to school or are you enrolled in an employment training program?
5. Do you receive routine medical care? Where do you go when you need immediate medical or dental care?
6. Do you participate in any other community-based services (such as community centers, counseling, etc)?
7. Have you been arrested since you left Stopover?
8. What did you like best about Stopover?
9. What did you like least about Stopover?
10. What would make Stopover better?

EXIT DATE:_____ SURVEY DATE:_____

5 Days 30 Days 90 days 180 days 1 year

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO

YES NO