

ATTACHMENT IV

FEEDBACK FORM FROM CBT STUDENT

NAME _____
POSITION _____
COUNTY NAME _____
COURSE NAME _____

Please help us to assure the usefulness of this course by completing the questions below. Use more paper as needed.

Do you have previous experience with the Medicaid program? (Circle one.) YES NO
If you circled YES, please give the length of time you've spent in the program, and in what capacity: _____

Have you taken other Medicaid CBT course (s)? YES NO If you circled YES, which one(s)?

Also if you circled YES, is this course easier than, as easy as, or harder than the other Medicaid CBT course (s) that you have taken? _____

Please make any remarks you wish in order to explain your answer to this question:

Did you encounter any technical problems? YES NO If you circled YES, what were they?

Rank the clearness and understandability of this course from 1 to 7, 1 being absolutely crystal clear and perfectly understandable, and 7 being the opposite extreme. (Circle one.) 1 2 3 4 5 6 7 Make any remarks you wish to explain your ranking: _____

Do you think that any part of the subject matter needs more said about it than what was in the course? YES NO Do you think any major portion of the topic was left out of the course? YES NO Please go into detail if you answer YES to either or both of these questions:

Indicate the ability of this course to hold the student's attention, from 1 to 7, 1 being totally absorbing and 7 denoting the opposite extreme. (Circle one.) 1 2 3 4 5 6 7 Make any remarks you wish to explain your ranking:

Make any other comments, suggestions, complaints, that you wish (please use additional paper if needed): _____

SEND THE COMPLETED FEEDBACK FORM TO:

MARJORIE MORRIS, CHIEF, MEDICAID ELIGIBILITY UNIT
DIVISION OF MEDICAL ASSISTANCE
2512 MAIL SERVICE CENTER
RALEIGH, NC 27699-2512
COURIER #56-20-06
FAX (919) 715-8548