

**LTC Nursing Facility/Hospice WEBINAR EVALUATION**

**Please fax completed evaluation to 512-506-7002**

Webinar Name: LTC – Nursing Facility/Hospice Webinar

Webinar Date/Time: \_\_\_\_\_

Presenter (s): Linda Wiley

Which of the following best describes your role?

- Healthcare Provider (e.g. Physician, Nurse)
- Medical Office Manager/Staff (non billing staff)
- State Agency Employee

*Please use the following scale to answer the following questions:*

1. *Strongly Disagree*
2. *Somewhat Disagree*
3. *Somewhat Agree*
4. *Strongly Agree*

*Please consider only your experience with the webinar you attended:*

- |  |   |   |   |   |
|--|---|---|---|---|
| 1. The webinar enhanced my understanding of the benefits of the LTC Online Portal    | 1 | 2 | 3 | 4 |
| 2. The requirements for entering all forms and assessments on the LTC Online Portal. | 1 | 2 | 3 | 4 |
| 3. Available resources for assistance  | 1 | 2 | 3 | 4 |
| 4. The information presented was clear and concise.                                  | 1 | 2 | 3 | 4 |
| 5. I feel confident in my ability to apply the information presented.                | 1 | 2 | 3 | 4 |
| 6. The presenters were effective and engaging.                                       | 1 | 2 | 3 | 4 |
| 7. The presenters answered questions clearly and completely.                         | 1 | 2 | 3 | 4 |
| 8. The Webinar format for this workshop topic was valuable and user friendly.        | 1 | 2 | 3 | 4 |
| 9. Overall, I was satisfied with the webinar.  | 1 | 2 | 3 | 4 |

Please let us know what topics you would like more information on. \_\_\_\_\_

Please fax completed form to TMHP at 512-506-7002.

Please provide any additional comments on your experience at this webinar. \_\_\_\_\_

Please consider only your experience with the webinar you attended:

Why did you attend? Check all that apply.

- In-person workshop was full
- Workshop was held at an inconvenient time
- Workshop was held at an inconvenient location
- Did not learn about workshops in time to register
- Attended workshop, using online as a *refresher*
- No budget for out-of-office training
- My organization does not allow travel for training
- Other: \_\_\_\_\_

Please provide your contact information, *only* if you would like to be contacted by a TMHP Provider Representative.

Name: \_\_\_\_\_

Provider Name and Provider Identifier: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone Number: \_\_\_\_\_