

Ohio Department of Medicaid  
**EMPLOYEE EXIT QUESTIONNAIRE**

Thank you for your service to the agency. We ask your cooperation by informing us of your reason for leaving the Ohio Department of Medicaid, and to provide us with your view of the agency. Please be honest while filling out the questionnaire. The information is considered confidential unless disclosure is unavoidable (e.g., claims of legal conduct). Your responses will not be available outside the Human Resources Unit, and will not be used for reference checks or future employment. The sole purpose of the questionnaire is to assist our agency improve working conditions, policies, and procedures; we appreciate your assistance. Please return this questionnaire directly to:

**Attn: Human Resources/Recruitment Section**  
**Ohio Department of Medicaid**  
**50 West Town Street, 5<sup>th</sup> Floor**  
**Columbus, OH 43215**

<b>Sex</b>	
<input type="checkbox"/> Male	<input type="checkbox"/> Female
<b>Race</b>	
<input type="checkbox"/> Black	<input type="checkbox"/> Asian or Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> American Indian or Alaskan Native
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other
<b>Disability</b>	
<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>Employment with ODJFS</b>	
From Mo./Yr. _____	To Mo./Yr. _____
Most Recent Classification	Office/Division
<b>Type of Separation</b>	
<input type="checkbox"/> Retirement	<input type="checkbox"/> Resignation
	<input type="checkbox"/> Other
<b>Reason for Leaving</b> <i>(Mark all that apply)</i>	
<input type="checkbox"/> Job with another state agency	<input type="checkbox"/> Job with private industry
<input type="checkbox"/> Job mobility	<input type="checkbox"/> Salary
<input type="checkbox"/> Supervisor(s)	<input type="checkbox"/> Co-Worker(s)
<input type="checkbox"/> Other <i>(Please explain)</i> _____	

**Please give your honest opinion concerning the following:**

1. Salary
2. Benefits
3. Policies and Procedures (e.g., sick leave)
4. Work Duties and Responsibilities
5. Tools/Training Provided to Adequately Complete Your Job
6. Direct Supervision
7. Co-workers
8. Opportunities for Promotions
9. Physical Work Environment
<b>Did you receive training from the agency's Bureau of Civil Rights regarding Medicaid IPP. 9002 Discrimination and Sexual Harassment Prevention?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Did you personally experience any discrimination while you were employed with Medicaid?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please explain
<b>Did you personally witness any discriminatory practices while you were employed with Medicaid?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, please explain
<b>If you marked "Yes" to either of the last two questions, did you make a supervisor and/or the Bureau of Civil Rights aware of the incident(s)?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No

**Please make any recommendations or suggestions, which you feel would assist Medicaid in improving the work environment or enhancing the efficiency of our processes/procedures:**

**What did you like least in your position?**

**What did you enjoy most about working with Medicaid?**

**Thank you for taking time to fill out the Exit Questionnaire. Your comments are valuable to our agency and will be carefully reviewed.**

Name *(optional)*