MIDDLESEX
COUNTY • NJ

OFFICE OF AGING AND DISABLED SERVICES

NEEDS ASSESSMENT SURVEY

1. **Today's date:**
2. **This survey is being filled out by:** ***(Check all that apply)***

   Older Adults (60+)   A person of any age with a disability   Family Caregiver
   Friend/Neighbor Caregiver   Professional Caregiver   Other

Demographics ***(The following questions pertain to the older adult and/or person with a disability)***

3. **Age**   4. **Gender**   5. **Zipcode**
6. **What type of disability(ies) do you have?**

   Alcoholism   Alzheimer's Disease   Amputation   Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease   Anxiety Disorder   Arthritis
   Attention Deficit/Hyperactivity Disorder (ADHD)   Auditory Processing Disorder   Autism Spectrum
   Back Impairment   Bipolar Disorder   Bladder Impairment   Bleeding Disorder
   Blindness/Low Vision   Brain Injury   Burn Injury   Cancer
   Chronic Fatigue Syndrome/Myalgic Encephalomyelitis   Chronic Pain   Colorblind/Color Vision Deficiency   Deafness   Depression   Diabetes   Drug Addiction
   Eating Disorders   Epilepsy/Seizure Disorder   Fibromyalgia
   Gastroesophageal Reflux Disease (GERD, Acid Reflux, Heartburn)   Gastrointestinal Disorders
   Hearing Impairment   Heart Condition   Hepatitis   Intellectual Impairment/Learning Disability
   Leg Impairment   Lupus   Migraines   Multiple Sclerosis   Muscular Dystrophy
   Obesity   Obsessive Compulsive Disorder (OCD)   Parkinson's Disease   Personality Disorder
   Phobias   Poliomyelitis (Polio)/Post Polio   Post-Traumatic Stress Disorder (PTSD)
   Renal/Kidney Disease   Respiratory Impairments   Schizophrenia   Shingles
   Sickle Cell Anemia   Skin Conditions   Sleep Disorder   Speech-Language Impairment
   Spina Bifida   Stroke   Stuttering   Thyroid Disorders   Tourette Syndrome

7. **What is your primary language?**   English   Spanish   Other
8. **Do you identify as lesbian, gay, bisexual, transgender or other?**   Yes   No
9. **What is your race/ethnicity?** ***(Check all that apply)***

   Asian or Pacific Islander   Black non–Hispanic   Hispanic/Latino
   White non–Hispanic   Native American or Alaskan Native   Other

10. **What is your marital status?** ***(Check only one)***

    Single   Live w/ partner   Married   Divorced/Separated   Widowed

11. **Which best describes your education level?** ***(Check only one)***

    Less than 11 years   High School   College Degree   Graduate or professional degree

12. **Total Annual Income: If married, include both yours and your spouse's income**

    Less than $15,000 $15,000 - $24,999 $25,000 - $34,999 $35,000 - $44,999
    $45,000 - $64,999 $65,000 - $84,999 $85,000 - $99,999 $100,000+

13. **Do you currently work/volunteer?** Yes No No, but I'd like to

14. **Please indicate whether you are a:** Veteran Spouse/Widow of a Veteran None

Service Access Information

15. **What program and services have you used in the past 12 months?** ***(Check all that apply)***

Adult Day Care Assistive Technology Care Management Caregiver Support Groups

Caregiver Assistance Congregate Meals (on site) Emergency Preparedness

Financial Assistance Friendly Visits Health Education Home Care

Home Delivered Meals Home Modifications Information & Assistance

Language Translation Legal Assistance Medicare Counseling Minor Home Repair

Physical Activities Prescription Assistance Retirement Education Social Activities

Transportation Services Other

16. **What program and services have you needed and NOT RECEIVED?** ***(Explain what happened)***

17. **What difficulties have you encountered obtaining services?** ***(Check all that apply)***

Eligibility Inadequate/no insurance Lack of assistive devices

Lack of availability of services Lack of knowledge about services Language barrier

Transportation Unsafe walking outside Other

18. **How did you learn about the services available in the County?** ***(Check all that apply)***

211 Line Internet Library Office of Aging & Disabled Services Police

Senior Center Social Service Agency Television Visiting Nurse Association

Word of Mouth Other

19. **Have you found Middlesex County facilities accessible?** Yes No I've never been

20. **Have you ever obtained services directly through the Middlesex Office of Aging and Disabled Services?**

Yes No Don't remember

Transportation Needs *(Only respond section if you have difficulty getting public transportation)*

21. **What are the main issues?** ***(Check all that apply)***

Can't afford Does not go to the places I need to go Don't know how to use it

Have to rely on others Not accessible due to my disability Not available

Other

Housing Information

22. **Do you currently** Own Rent without subsidy No stable home

Live free of charge with family/friends Live in subsidized housing

23. **In what type of housing do you currently live?**

Private home/apartment Group Home Shelter Boarding Home Assisted Living

Senior Housing Nursing Home Other

24. **Does your current housing meet your needs?** ***(Check all that apply)***

Yes No, I can't afford rent/mortgage No, need home modifications

No, I don't feel safe in my home/neighborhood Other

25. **Are you able to perform household chores** ***(Cleaning, cooking, laundry, etc.)?*** Yes No

26. **Are you able to pay rent/taxes?** Yes No

27. **Are you able to pay for home heating?** Yes No

28. **Including yourself, how many people live in your household?** ***(If you live alone, enter 1)***

Finances

29. **Do you have trouble paying bills?** Yes No

30. **Have you missed payments in the last year?** Yes No

31. **Have you had any late fees in the last year?** Yes No

32. **Have you made any double payments in the last year?** Yes No

General Well-Being

33. **Please indicate if you have had a problem with any of the following in the past 12 months.**

	No Problem	Minor Problem	Major Problem
Physical health			
Feeling lonely, sad, isolated			
Affording medication			
Performing everyday activities			
Have few activities/feeling bored			
Injuries due to falls			

34. **Have you fallen in or around your home in the last 6 months, or are you afraid you might fall?**

Yes No

35. **If you have fallen, were you treated in:**

Doctor's Office Emergency Department Urgent Care Required no medical treatment

Other

36. **If you were treated in Emergency Department, choose option that best describes what took place:**

Admitted for an inpatient stay at hospital Treated and released

Went to a rehab facility afterwards

37. **Do you participate in fall prevention activities at your local senior center or in the community?**

Yes No

38. **If yes, which ones?** ***(Check all that apply)***

Bingocize Healthy Bones Matter of Balance Tai Chi

39. **If no, why?** ***(Check all that apply)***

Lack of time Lack of transportation Don't think it's important for my health

Didn't know they were available

40. **In the past year, have you, a family member or friend conducted a Home Safety Assessment to identify fall risks** ***(Includes loose rugs, trip hazards, lack of bathroom grab bars, poor lighting, etc.)?***

Yes No

40. **Would you be interested in participating in falls training and risk assessment in the future?**

Yes No

Food Security

42. **In the last 12 months, did you eat less than you felt you should because there wasn't enough money for food?**

    Yes No

43. **In situations when you are unable to shop, cook, and/or feed yourself, do you have someone who can help you?**

    Always Sometimes Never

44. **I keep emergency food supplies on hand:** Yes No

Safety *(Only respond this section if you have been a victim of a crime in the past 12 months)*

45. **If you have been a victim of a crime in the past 12 months, what type of crime? *(Check all that apply)***

    Financial exploitation* Physical abuse* Emotional/psychological* Sexual abuse*

    Identity theft Theft/Burglary Other

    *If this has or is happening, please call Adult Protective Services at 732-745-3635

46. **If you have been a victim of a crime in the past 12 months, who did you notify? *(Check all that apply)***

    I did not report it Police Adult Protective Services Other

Caregiver Information *(Only respond to section if you are a caregiver of a person who is 60+ and/or a person with a disability)*

47. **Are you a caregiver for someone who is 60+ and/or a person with disability(ies)?** Yes No
48. **For whom do you provide care?**

    Spouse Parents Life Partner Grandparent Minor Age Child (20 and younger)

    Adult Child (21+) Neighbor Son/Daughter In-law Sibling Other

49. **Does the individual for whom you care live in your home?** Yes No
50. **Does the individual have memory problems and/or dementia?** Yes No
51. **Do you feel overwhelmed and/or stressed in providing care?** Yes No
52. **On a scale of 1 to 10, with 1 being "not stressful" to 10 being "extremely stressful," please rate your current level of stress:**
53. **Is there specific information or services that you think could help you? *(Check all that apply)***

    Financial Support Having someone to talk to Connecting with agencies to get services

    Taking a break for myself Other

54. **Are you a paid caregiver?** Yes No
55. **Is there anyone you can call in an emergency to fill in for you as a caregiver?** Yes No
56. **Distance to your care recipients home?** 0-5 Miles 5-15 Miles 15-30 Miles

    30-50 Miles 50-100 Miles Over 100 Miles

57. **Do you have a chronic health condition or have you experienced a recent health crisis?** Yes No
58. **If Yes, Has this health condition affected your ability to be a Caregiver?** Yes No
59. **Have your caregiver responsibilities ever affected your employment?** Yes No
60. **Which of the following tasks do you assist the care recipient with?**

    Personal Tasks (ADL) Homemaker Chores (IADL) Transportation Managing Finances

    Healthcare (Doctors visits, Medication Management) Supervision Emotional Support

    Other

61. **Do you need information, education, and/or training about the following?** ***(Check all that apply)***

- Choosing In-Patient Long-term Care Facility
- Fall Prevention
- Hands on skills training for personal care tasks (Bathing, Grooming, Toileting, etc.)
- Home Safety and/or Home Modifications
- How to care for yourself while caring for others
- How to get help from other family members
- How to provide care to an aging individual
- Individual Counseling Options
- In-Home Support Services
- In-Patient Short-term Respite Care
- Legal/Financial Issues (Power of Attorney, Living Will, Guardianship)
- More information about care recipients' conditions/diagnosis
- Online Information and Supports
- Support Groups

Thank you, we sincerely appreciate the time you have taken to complete this survey.

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