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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