



Division of Aging and Adult Service  
2011-2012 Countywide Assessment of Needs of  
Older Adults and Family Caregivers



**Are you 55 years or older?**

**OR**

**Are you an adult family member, neighbor, or friend  
who provide unpaid help to an elderly person or some-  
one with Alzheimer's or dementia?**

**WE NEED YOU!**

By completing the enclosed survey, you will help the County and the Commission on Aging understand the needs and concerns of older adults and family/informal caregivers. This will guide us in determining our goals, activities, and funding priorities for the next 4 years. While you may find some of the questions personal, your responses are kept confidential. We do not ask for your name or any other information that will identify you as the responder.

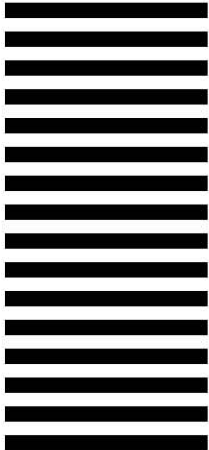
For more information, please contact **Ana Bagtas** at **415-473-6947** or e-mail **abagtas@co.marin.ca.us**. Mail your completed survey by **December 1, 2011**.

FOLD HERE. TAPE THE ENDS AND MAIL. NO POSTAGE NECESSARY.

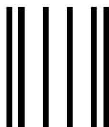


DIVISION OF AGING & ADULT SERVICES  
DEPARTMENT OF HEALTH & HUMAN SERVICES  
10 N San Pedro Rd Ste 1023  
San Rafael, CA 94903-9876

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**INSTRUCTIONS: Please respond to the following questions based on the perspective of the person checked below. Complete one survey per person.**

The information I'm providing in this survey is for (check **only one**):

- A client     Myself  
 A family member/friend I'm taking care of

**HEALTH & WELL-BEING**

1. Compared to other people the same age, you consider your health to be:

- Excellent     Good     Fair     Poor

2. Have you had any of the following check-ups in the past 12 months? Check all that apply:

- Regular dental care     Regular eye care  
 Routine medical or physical examination

3. Tell us about your nutritional health by answering the following questions:

Have you made changes to your lifelong eating habits due to health problems?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you eat fewer than 2 meals a day?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you eat less than 5 servings of fruits and vegetables a day?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you eat less than 2 servings of milk/dairy/calcium fortified products a day?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have tooth or mouth problems that make it hard for you to eat or chew?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you run out of money for food most months?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you eat alone most of the time?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you take 3 or more prescribed or over-the-counter drugs per day?	<input type="checkbox"/> Y <input type="checkbox"/> N
Without trying, have you gained or lost 10 or more pounds in the last 6 months?	<input type="checkbox"/> Y <input type="checkbox"/> N
Are you physically unable to shop, cook, or feed yourself?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you have 3 or more drinks of liquor, wine, or beer almost every day?	<input type="checkbox"/> Y <input type="checkbox"/> N

4. Have you experienced any of the following in the past 12 months? Check all that apply:

- Arthritis                       Alzheimer's/dementia  
 Cancer                          COPD/lung disease  
 Diabetes                        Enlarged prostate  
 Glaucoma, macular degeneration or cataract  
 Heart disease                 High blood pressure  
 Injury from a fall     Kidney/bladder problem  
 Long periods of sadness or depression  
 Obesity                          Parkinson's  
 Other \_\_\_\_\_

5. Do you need help performing any of the following personal activities? Check all that apply:

- Bathing                                 Cooking  
 Dressing                                Driving  
 Eating                                     Exercising  
 Heavy housework                     Light housework  
 Managing medications             Shopping  
 Money management                 Toileting  
 Transferring in/out of bed or chair  
 Using a phone                         Using transportation  
 Walking                                 Other \_\_\_\_\_

6. If you checked any of the daily personal activities listed above in #5, who is helping you perform those tasks? Check all that apply:

- I do not need any help     Spouse/partner  
 Adult children                         Family members  
 Friends                                  Paid caretaker  
 Other \_\_\_\_\_

7. How many times have you been in the hospital due to an injury or major illness in the past 12 months?

- None     1-2 times     3 or more times

8. Additional comments:

**COMMUNITY CONNECTION &  
QUALITY OF LIFE**

9. Compared to other people the same age, you consider your quality of life to be:

- Excellent     Good     Fair     Poor

10. What kinds of activities or programs do you participate in? Check all that apply:

- Arts & crafts  
 Classes and lectures  
 Fitness & exercise  
 Gambling/going to casinos  
 Movies  
 Museums and art exhibits  
 Senior lunch/congregate meal program  
 Senior Center/Community Center activities  
 Social clubs (bridge, bocce, quilting, Rotary)  
 Synagogue, church, faith/spiritual groups  
 Trips (not including casinos)  
 Volunteering  
 Walking/hiking  
 Watching TV  
 Other \_\_\_\_\_

11. How often do you participate in these activities? Check only one:

- A few times a week     At least once a week  
 At few times a month     A few times a year  
 I do not participate in any program/activity

12. How do you get to places where you need to go? Check all that apply:

- I drive     Bus/public transportation  
 Family/friend     Taxi/private service  
 Volunteer driver     West Marin Senior Svcs  
 Whistlestop     Other: \_\_\_\_\_

13. How often do you see your family members or friends?

- Never     A few times a week  
 At least once a week     A few times a month  
 A few times a year     Other \_\_\_\_\_

14. What ways are you using computer technology and the Internet? Check all that apply:

- Communicate with my doctor/provider  
 E-mail  
 Games/entertainment     I do not use a computer  
 Search the web for info  
 Skype  
 Other: \_\_\_\_\_

15. How do you find out about senior services or issues? Check all that apply:

- 457-INFO     211  
 Family/friends     Great Age newsletter  
 Internet     Network of Care  
 Marin IJ     Senior Center  
 Service provider     Social/case worker  
 Whistlestop     Other: \_\_\_\_\_

16. Have you experienced any of the following issues or problems in the past 12 months? Check all that apply:

- Abuse: financial, physical, or psychological  
 Crime     Finding a doctor  
 Finding home care     Finding housing  
 Getting services     Insurance disputes  
 Legal problems     Unemployment  
 Underemployment     Other \_\_\_\_\_

17. Have you experienced financial hardship in the past 12 months that makes any of the following difficult to afford? Check all that apply:

- Food costs     Fuel/transportation cost  
 Home repair     Home care  
 Insurance costs     Medical bills  
 Medication costs     Rent/mortgage payment  
 Taxes     Utility bills  
 Other \_\_\_\_\_

18. Additional comments:

## TELL US ABOUT YOURSELF

19. City/town of residence: \_\_\_\_\_

20. Age: \_\_\_\_\_

21. What is your race/ethnicity?

- Asian  
 Black/African American  
 Caucasian/White  
 Hispanic/Latino  
 Native American/Alaskan Native  
 Native *Hawaiian*/Pacific Islander  
 Mixed Race  
 Other \_\_\_\_\_

22. Primary language: \_\_\_\_\_

23. Gender identity:

- Male       Female       Transgender

24. Sexual orientation:

- Bisexual       Gay  
 Heterosexual       Lesbian

25. Housing situation:

- Live in assisted living or nursing home facility  
 Live in affordable/HUD/Section 8 housing  
 Live with family/friend free of charge  
 Live in independent living senior housing  
 Own home with mortgage  
 Own home without mortgage  
 Rent (apartment/home)  
 Other \_\_\_\_\_

26. How many years have you lived in Marin County? \_\_\_\_\_

27. Including yourself, how many people live in your household? \_\_\_\_\_

28. Who else are living with you in your home?

Check all that apply:

- Adult children       Grandchildren  
 Paid caretaker       Roommate  
 Spouse/partner       Other relative  
 Other \_\_\_\_\_

29. Monthly personal income: \$ \_\_\_\_\_ /mo

30. Monthly household income: \$ \_\_\_\_\_ /mo

31. Income source. Check all that apply:

- Employment       Pension  
 Social Security       SSI/General Assistance  
 Unemployment Insurance  
 Other \_\_\_\_\_

32. Relationship status:

- Divorced       Married       Partnered  
 Separated       Single       Widowed

33. Employment status:

- Full-time       Part-time  
 Retired       Unemployed  
 Underemployed       Other \_\_\_\_\_

34. Are you looking for employment?

- Yes       No

35. Do you provide care without pay to any of the following individuals who may be disabled, frail, or ill? Check all that apply:

- N/A       Spouse/partner       Adult child  
 Friend       Grandchild       Other family  
 Other \_\_\_\_\_

36. Approximately how many hours of care or help do you provide?

- N/A       less than 5 hrs/wk  
 6-20 hrs/wk       21-30 hrs/wk  
 31-40 hrs/wk       More than 40 hrs/wk

37. Have you had to quit your job or work part-time to due to caregiving responsibilities?

- Yes       No

38. Other information you'd like to share: