



**ONEIDA COUNTY
OFFICE FOR THE AGING & CONTINUING CARE**

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ANTHONY J. PICENTE, JR.
County Executive

MICHAEL J ROMANO
Director

MEMORANDUM

TO: Oneida County Residents
FROM: Oneida County Office For the Aging
DATE: August 19, 2019
RE: Survey

Each year the Oneida County Office for the Aging/Continuing Care engages with as many members of the community as possible to help identify the ever changing needs of older residents and caregivers. As the lead planning and advocacy agency in Oneida County, the role of Office For the Aging is to identify needs of the targeted population we serve as well as gaps in the current aging services delivery system. We ask that you share this survey with anyone you think may be interested, and also take time to complete it on behalf of yourself or someone you may be caring for.

We thank you for taking the time to fill this out, as it helps our agency, as well as the seniors within our communities that we serve.

Surveys can be returned to:

Oneida County Office For the Aging
& Continuing Care
120 Airline Street
Suite 201
Oriskany, NY 13424



Oneida County Office for the Aging/Continuing Care

Needs and Concerns of Older Adults in Oneida County

As the Area Agency on Aging, the Oneida County Office for the Aging/Continuing Care is required to assess the need for supportive services among people 60 years of age and older. We would appreciate your help with this planning process. Please fill out this survey and return it at your earliest convenience. All of your information is confidential.

Name (optional) _____ Male ____ Female ____
(please print)

1. I live in the city/village of _____ I live in the township of _____.
2. Are you aware that there is an Oneida County Office for the Aging?..... **Yes** ____ **No** ____
3. Are you aware that the Office for the Aging is a source of services and information for the senior population?..... **Yes** ____ **No** ____
4. How do you get information about services and benefits that older people are eligible to receive? **Please explain:**

5. Do you: **Own** ____ **Rent** ____ **Live in senior housing** ____ **Live with Family** ____
6. **Date of birth:** ____/____/____ **Spouse's date of birth:** ____/____/____
7. **Married** ____ **Widowed** ____ **Never married** ____ **Divorced/Separated** ____
8. **White** ____ **Black** ____ **Hispanic** ____ **Asian/Pacific Islander** ____ **American Indian/Alaskan Native** ____
9. How many people live in your household? _____
10. (If you live alone) Is your income less than \$2,318 a month? **Yes** ____ **No** ____
(If you live with your spouse) Is your income less than \$3,031 a month?
..... **Yes** ____ **No** ____
11. Do you feel you have enough contact with others? (Getting out, seeing friends or relatives?)
..... **Yes** ____ **No** ____
12. Are you able to get groceries and prepare adequate meals? **Yes** ____ **No** ____
13. Do you feel the following are adequately accessible to you?
 - a. Banking **Yes** ____ **No** ____
 - b. Medical Services **Yes** ____ **No** ____
 - c. Groceries **Yes** ____ **No** ____
 - d. Voting..... **Yes** ____ **No** ____
 - e. Community Activities **Yes** ____ **No** ____

HEALTH

14. Do you have health insurance? **Yes** ____ **No** ____
15. Do you have enough health insurance to cover your needs? **Yes** ____ **No** ____
16. Do you have dental coverage? **Yes** ____ **No** ____
17. Do you have prescription drug coverage? **Yes** ____ **No** ____

18. Do you have difficulty understanding health insurance coverage? **Yes** ___ **No** ___
19. Do you have trouble finding a doctor who accepts Medicaid? **Yes** ___ **No** ___
20. Do you have trouble finding a doctor who accepts Medicare? **Yes** ___ **No** ___
21. Do you have difficulty filling out medical forms? **Yes** ___ **No** ___

SECURITY

22. Do you feel safe in your home? **Yes** ___ **No** ___
23. Do you feel lonely or depressed? **Yes** ___ **No** ___
24. Do you know who to call for help? **Yes** ___ **No** ___

INCOME

25. Do you have enough income to meet your basic needs? **Yes** ___ **No** ___
26. What bills are you having difficulty paying? (*Check all that apply*) **Rent/Mortgage**
 ___ **Home repairs** ___ **Utility bills (fuel/electric)** ___ **Groceries** ___
 ___ **Medical Care** ___ **Prescriptions** ___ **Other (specify):**

27. Can you understand and fill out tax forms, property tax exemptions, etc.?
 **Yes** ___ **No** ___

TRANSPORTATION

28. Are you able to get to the doctor, grocery store, etc.? **Yes** ___ **No** ___
29. Do you use public transportation? **Yes** ___ **No** ___
30. Is there adequate public transportation to meet your needs? **Yes** ___ **No** ___
31. Do you drive your own car? **Yes** ___ **No** ___
32. Do you use Dial-A-Ride? **Yes** ___ **No** ___

CAREGIVING

33. In the past year has a member of your household needed help with bathing, dressing, meal preparation or other personal care?..... **Yes** ___ **No** ___
34. Are you taking care of anyone in your household, or someone living nearby? (*running errands, fixing meals, driving them to medical appointments, bathe, etc.*)
 **Yes** ___ **No** ___
35. If you had trouble care for yourself at home and didn't have a spouse or friend to provide that care, what would you be most likely to do?
 a. ___ **move in with adult children or other relatives**
 b. ___ **remain at home and hire an aide service**
 c. ___ **move to a retirement community**
 d. ___ **move to an adult home or Nursing home**
 e. ___ **make do the best you could**
36. If you are a caregiver, what do you need help with?

