**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?

**a. ____ dealing with agencies to get services**
**b. ____ having someone to talk to/counseling**
**c. ____ taking a break to meet your own needs**
**d. ____ handling money matters**
**e. ____ getting information**

**Comments:**

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Would you like someone from the Office for the Aging to contact you?

If yes, your name: _____ phone: _____
*(please print)*

Thank you for taking the time to help us. Please return this survey at your earliest convenience to:

**Oneida County Office for the Aging/Continuing Care**

**120 Airline Street, Suite 201**

**Oriskany, New York 13424**