

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 1. Demographics

### 1. Gender:

Female

Male

### 2. Age:

### 3. Education:

Grade school or less

Some college (no degree)

Some graduate study

Some high school

Associate degree (AA or 2-year college)

Graduate degree

Graduated high school or GED

College graduate (BA/BS)

Doctorate degree

### 4. Monthly income before taxes \$:

### 5. Number of Persons in Household:

One (live alone)

Two

Three

Four

Five

Six

Seven

Eight or more

### 6. If you live with one or more people are they:

Relatives

Non-related

Both

Not Applicable

### 7. Marital Status:

Single, never married

Separated

Remarried

Married

Divorced

Living with a partner

Widowed

### 8. If you answered "widowed" for #7, when did your spouse die? If you did not answer "widowed," move on to #9.

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 9. Race and Ethnicity:(Check all that apply)

- American Indian / Alaska Native       Hispanic       Two or more races
- Asian       Native Hawaiian or Pacific Islander       Decline to state
- Black or African American       White
- Other (please specify)

## 10. Country of Birth:

United States

Other (please specify)

## 11. What county do you currently reside in?

Crook County

Jefferson County

Deschutes County

Confederated Tribes of Warm Springs

## 12. What city do you currently reside in?

## 2. Veteran Status and Benefits

### 1. Have you ever served in the military?

No

Yes

### 2. Have you applied and/or received veteran's benefits?

No

Yes

Not applicable

## 3. Giving and Receiving Assistance

### 1. Do you have meals home delivered?

No

Yes

### 2. If yes to #1, how many day(s) per week are your meals home delivered? If no to #1, move on the #3.

	One	Two	Three	Four	Five	Six	Seven
Day(s) per week	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**3. Do you go to a site for congregate dining?**

No

Yes

**4. If yes to #3, how many day(s) per week do you attend congregate dining? If no to #3, move on to #5.**

	One	Two	Three	Four	Five	Six	Seven
Day(s) per week	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**5. Do you receive help for meal preparation and clean-up, housecleaning, laundry or sewing?**

No

Yes

**6. If yes, do you currently get help from \_\_\_\_\_ for this activity?**

Family

Volunteer

Other Source

Friends

Central Oregon Council On Aging

Not applicable

**7. Do you need help or additional help with this activity?**

No

Yes

**8. Do you receive help with transportation to medical appointments, or to do shopping, banking, or other necessary trips?**

No

Yes

**9. If yes, do you currently get help from \_\_\_\_\_ for this activity?**

Family

Volunteer

Other Source

Friends

Central Oregon Council On Aging

Not applicable

**10. Do you need help or additional help with this activity?**

No

Yes

**11. Do you receive help with maintenance of your home, such as home repair or regular yard work?**

No

Yes

**12. If yes, do you currently get help from \_\_\_\_\_ for this activity?**

Family

Volunteer

Other Source

Friends

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Not applicable

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**13. Do you need help or additional help with this activity?**

No

Yes

**14. Do you receive help with personal care, such as bathing, toileting, brushing teeth, shampooing and hair care or dressing?**

No

Yes

**15. If yes, do you currently get help from \_\_\_\_\_ for this activity?**

Family

Volunteer

Other Source

Friends

Central Oregon Council On Aging

Not applicable

**16. Do you need help or additional help with this activity?**

No

Yes

**17. How many younger generations of family are you helping out? By 'helping out' we mean things like help with shopping, home maintenance, transportation, financial management, checking on them by phone or making arrangements for care. (Check all that apply)**

Sibling / Cousin

Grandchildren

Not Applicable

Children / Niece or Nephew

Great-Grandchildren

**18. In total, about how many hours per week would you say you spend helping them out? If you don't help your family move on to #19.**

**19. Do you currently help out elderly or disabled relative or friend? This includes someone who lives with you or who lives somewhere else. By 'helping out' we mean things like help with shopping, home maintenance, transportation, financial management, checking on them by phone, or making arrangements for care.**

No

Yes

**20. If yes to #19, about how many hours per week would you say you spend helping them out? If no, move on to #21.**

**21. Please tell me how much you agree with the following statement: "Helping my family and friends is negatively affecting my financial security."**

Strongly Disagree

Disagree

Undecided

Agree

Strongly Agree

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**22. Do you feel you have the support necessary to help you deal with the challenges of caring for family member(s) or friend(s)?**

No

Yes

Not Applicable

**23. What types of services might be helpful to you in meeting the challenges of helping out your family member or friend? (Check all that apply)**

Information of services that might help you or the person you care for

A day program to provide help with daily care giving

None of the above

Caregiver Education or Training (classes, workshops, materials)

Respite care that would provide periodic or weekend relief

Not Applicable

Other (please specify)

**24. Would you like more information on these types of services?**

No

Yes (Please contact: Central Oregon Council On Aging at(541) 548-8817)

## 4. Sources of Information Used to Find Services

**1. People often go to a variety of sources to get information about services they might need or want. What are the main ways you get this type of information? (Check all that apply)**

Spouse

Parks and Recreation

Church

Children

Other county / state offices

Newspaper/radio/TV

Parents /other family

Private Agency

Library

Friends / neighbors

Professional (Dr. / nurse / social worker / private case manager)

Phone book

Department of Human Services

Clinic or medical center

Computer / Internet

Health Department

Call-in medical help line

Insurance company

211 phone service

Senior center or meal site

Probably wouldn't contact anyone

Other (please specify)

**2. Please list your favorite internet sites you visit for information on services?**

## 5. Physical Health

**1. Compared to others in your age group, how would you describe your usual state of health?**

Excellent

Very Good

Good

Fair

Poor

**2. Are you physically disabled?**

No

Yes

**3. Do you frequently eat alone?**

No

Yes

**4. How many meals do you eat a day?**

**5. Which of these statements best describes the food eaten in your household in the last 12 months?**

I have enough of the kinds of food I want to eat

Sometimes I don't have enough to eat

Don't know

I have enough but not always the kinds of food I want

Often I don't have enough to eat

**6. How many servings of fruit you eat each day? For example, a serving size for fruit is 1 medium-size fruit; 1/2 cup of fruit (raw, cooked, frozen or canned in 100% fruit juice); 3/4 cup of 100% fruit juice, or 1/4 cup dried fruit.**

**7. How many servings of vegetables do you eat each day? For example, a serving size for vegetables is 1/2 cup vegetables, including beans and peas (raw, cooked, frozen, or canned); 3/4 cup of 100% vegetable juice, or 1 cup raw, leafy vegetables.**

**8. Do you find as you age there are certain foods you can no longer digest well?**

No

Yes

**9. Have you changed your eating habits to adjust to not eating these foods and if so, what have you replaced them with?**

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 6. Physical Activity

### 1. Which types of physical activities do you engage in the most right now? (Check all that apply)

- |   |                                    |   |
|---|------------------------------------|---|
| <input type="checkbox"/> Walking                | <input type="checkbox"/> Jogging   | <input type="checkbox"/> Stress reduction classes such as yoga, tai chi, qigong |
| <input type="checkbox"/> Gym workout            | <input type="checkbox"/> Housework | <input type="checkbox"/> Don't exercise   |
| <input type="checkbox"/> Workout at home        | <input type="checkbox"/> Gardening |   |
| <input type="checkbox"/> Exercise class         | <input type="checkbox"/> Biking    |   |
| <input type="checkbox"/> Other (please specify) |                                    |   |

### 2. In an average week, how many days are you involved in any kind of physical activity?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> None             | <input type="checkbox"/> 3 days per week | <input type="checkbox"/> 6 days per week |
| <input type="checkbox"/> One day per week | <input type="checkbox"/> 4 days per week | <input type="checkbox"/> 7 days per week |
| <input type="checkbox"/> 2 days per week  | <input type="checkbox"/> 5 days per week |  |

### 3. On those days, on average how much time do you spend doing physical activities?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> 1-14 minutes per day  | <input type="checkbox"/> 45-59 minutes per day      | <input type="checkbox"/> Not applicable |
| <input type="checkbox"/> 15-29 minutes per day | <input type="checkbox"/> 60 minutes or more per day |   |
| <input type="checkbox"/> 30-44 minutes per day | <input type="checkbox"/> Don't know                 |   |

### 4. Based on your answer to the number of days and the amount of time you exercise, on a scale of 1 to 10 with 1 being inconsistent and 10 being highly consistent, how would you rate the consistency of your physical activities?

## 7. Health Insurance and Prescriptions

### 1. Do you have Medicare?

- |                             |                              |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

### 2. Do you have Supplemental Medicare?

- |                             |                              |
|-----------------------------|------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes |
|-----------------------------|------------------------------|

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**3. Do you have Medicaid?**

No

Yes

**4. Have you heard about the SHIBA (Senior Health Insurance Benefits Assistance) program?**

Yes

No

**5. Through the SHIBA program, would you like more information on Medicare Part D and/or Medicare advantage plans?**

No

Yes

**6. Do you have a medical/durable power of attorney?**

No

Yes

**7. Do you have an advanced directive?**

No

Yes

**8. Have you discussed your advanced directive with those who are close to you?**

No

Yes

Not applicable

**9. Do you have a POLST (Physician's Order for Life Sustaining Treatment)?**

No

Yes

**10. Please tell us how much you agree with the following statement: "The cost of my prescribed medication(s) is affordable."**

Strongly Disagree

Disagree

Undecided

Agree

Strongly Agree

Not applicable

## 8. Medical Screening and Vaccinations

**1. Have you had any of the following health screening procedures within the last five years?**

	No	Yes
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer	<input type="checkbox"/>	<input type="checkbox"/>
Colon/rectal cancer	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular health	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**2. Are you aware that Medicare benefits may cover all or some portion of these screenings?**

No

Yes

**3. Have you had any of the following vaccinations within the last five years?**

	No	Yes
Flu	<input type="radio"/>	<input type="radio"/>
Pneumonia	<input type="radio"/>	<input type="radio"/>
Hepatitis	<input type="radio"/>	<input type="radio"/>

**4. Are you aware that Medicare benefits may cover all or some portion of these vaccinations?**

No

Yes

**5. Do you go to your annual physical check-up?**

No

Yes

**6. How often do you visit the dentist?**

Every 6 months

Once a year

Irregularly

Never

**7. If you wear glasses or contact lenses is your current prescription adequate?**

No

Yes

Not applicable

## 9. Mental Health

**1. Over the past two weeks, how often have you been feeling bothered by the following problems? Feeling down, depressed, or hopeless?**

Not at all

Occasionally or a few days

Several days

More than half the days

Nearly every day

**2. Over the past two weeks, how often have you been feeling bothered by the following problem? Little interest or pleasure in doing things?**

Not at all

Occasionally or a few days

Several days

More than half the days

Nearly every day

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**3. Have you experienced problems with addictive behaviors such as smoking, excess drinking, prescription pill consumption, gambling, overeating, drug-use, and/or hoarding?**

No

Yes

**4. Have you sought counseling from a professional such as a psychologist, social worker, psychiatrist, clergy, or a primary care physician for depression, anxiety, or an addiction?**

No

Yes

Not applicable

**5. If you have not sought counseling, what are the primary reasons why? (Check all that apply)**

Cannot afford it

It is just seasonal

Don't won't anyone to know

Not sure who to talk to

Don't think it's serious

Not applicable

Uncomfortable / embarrassed

Don't think counseling will help

It will just get better / it will pass

Not accessible in area

Other (please specify)

## 10. Employment and Financial Security

A job needs to be paid for it to be considered employment.

**1. Which one of the following best describes your current employment status?**

Retired, but now working full-time

Working part-time, never retired

Retired, but now working part-time

Unemployed, looking for work

Retired, but looking for work

Unemployed, not looking for work

Retired and not looking for work

Never worked

Working full-time, never retired

Disabled, unable to work

**2. If you are currently working, are you working because:**

You have to

You want to

Both

Not applicable

**3. If you are younger than 65, do you plan to continue working past age 65?**

No

Yes

Not applicable

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**4. If you are planning to work past 65, what are the contributing factors? (Check all that apply)**

- Need the income                       Mental stimulation                       Passionate about cause  
 Need the benefits                       Social interaction                       Not applicable

**5. If you are currently working or looking for work, how many more years do you plan to continue working or looking for work, either full-time or part-time?**

Less than one year (enter  number of months):

1 year or more (enter  number of years):

**6. If you are currently working or looking for work, do you plan to:**

- Work full-time in your current occupation                       Pursue a part-time job in another field  
 Work part-time in your current occupation                       Not applicable  
 Pursue a full-time job in another field  
 Other (please specify)

**7. Which of the following statements describes how confident you feel you will be able to find a job once you are age 65 or retired?**

- Very confident     Somewhat confident     Undecided     Not too confident     Not confident at all     Not applicable

**8. Which of the following statements describes how confident you feel that you will be physically able to continue working for as long as you need or want to?**

- Very confident     Somewhat confident     Not too confident     Undecided     Not confident at all     Not applicable

**9. Which of the following statements describes how confident you feel that you will be able to continue to find work for as long as you need or want to?**

- Very confident     Somewhat confident     Undecided     Not too confident     Not confident at all     Not applicable

**10. Which of the following statements describes how confident you feel that you will be financially stable in retirement?**

- Very confident     Somewhat confident     Undecided     Not too confident     Not confident at all     Not applicable

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**11. If your social security was decreased by 10%, how confident would you feel about your financial stability?**

Very confident     Somewhat confident     Undecided     Not too confident     Not confident at all     Not applicable

## 11. Housing

**1. How many years or months have you lived in your current residence?**

**2. If you have a spouse/partner, do they live with you?**

No     Yes     Not applicable

**3. Do you have family members that live nearby?**

No     Yes

**4. Please tell me how much you agree with the following statement: "What I'd really like to do is stay in my current residence for as long as possible."**

Strongly agree     Agree     Neither agree or disagree     Disagree     Strongly disagree

**5. How confident are you that you will be able to afford to live in your current residence for as long as you would like? Do you feel . . .**

Very confident     Somewhat confident     Undecided     Not too confident     Not confident at all

**6. Do you currently rent or own your residence?**

Renting     Own Home     Neither, I live with another household

**7. Do you currently spend 30% or more of your monthly income on rental housing? This includes monthly rent plus average cost of monthly utilities (electricity, gas, water and sewer) and fuels (oil, kerosene and wood).**

No     Yes     Don't know     Not applicable

**8. Do you currently spend 30% or more of your monthly income on housing? This includes monthly mortgage, deeds of trust, or other debts on property, real estate taxes, fire, hazard, flood insurance, utilities and fuels, and condominium fees.**

No     Yes     Don't know     Not applicable

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**9. Does your current residence need any significant repairs, modifications or changes to allow you to remain in your home as you get older?**

No

Yes

**10. Would one of the modifications needed be . . . ?**

	No/Yes?	Are you planning to make this change? No/Yes/Not Applicable?
better cooling in the summer	<input type="text" value="6"/>	<input type="text" value="6"/>
better heating in the winter	<input type="text" value="6"/>	<input type="text" value="6"/>
easier access into or within your home such as a ramp, chairlift, wheelchair, or elevator	<input type="text" value="6"/>	<input type="text" value="6"/>
bathroom modifications such as grab bar, handrails, a high toilet, or non-slip tile	<input type="text" value="6"/>	<input type="text" value="6"/>
elimination of problems with insects, rodents, or other pests	<input type="text" value="6"/>	<input type="text" value="6"/>
structural changes or major repairs such as new roof or new plumbing	<input type="text" value="6"/>	<input type="text" value="6"/>
cosmetic or minor repairs such as painting or floor finishing	<input type="text" value="6"/>	<input type="text" value="6"/>

**11. What is the major reason for not planning to make the modifications listed above?**

Can't afford it

Don't trust anyone to do it

Can't find information to make the change

Not sure will still be in residence

Unable to do it yourself

No real need

Can't find contractor/workers/others to do it

I can't make the change, I am renting

Can't get to hardware or supply store

Other (please specify)

**12. Is there anything else that needs modification in your home to allow you to remain there as you get older? What is it?**

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**13. Are you planning to make this change?**

No

Yes

**14. Have you moved your residence within the last five years to reduce your housing costs?**

No

Yes

**15. Do you think that you will need to move to more affordable housing within the next five years?**

No

Yes

**16. Which of the following is the main reason you might need to move to more affordable housing within the next five years? (Check all that apply)**

Cost of rent

Cost of taxes

Cost of utilities

Cost of mortgage

Cost of maintaining your home

Not applicable

Other (please specify)

**17. How confident are you that you will be able to find something you can afford when you are ready to leave your current residence? Do you feel . . . ?**

Very confident

Somewhat confident

Undecided

Not too confident

Not confident at all

Not applicable

**18. Are there other barriers besides cost, that might keep you from moving should you need or want to? (Check all that apply)**

No, no other barriers

Not knowledgeable of other housing options

Not physically able to look for other housing

Children or other family want me to stay close by

Don't want to leave my neighborhood/neighbors

Nothing available in a good neighborhood

Other (please specify)

Don't want all the trouble of moving (packing, going through things, throwing out things)

Don't want to leave local services

Waiting list for subsidized housing is too long

Nothing near good transportation

Not applicable

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**19. Are you staying in current housing because it's your only choice?**

No

Yes

**20. Are you aware of other housing options?**

No

Yes

## 12. Safety and Security

**1. Overall, how safe would you say that you feel in your neighborhood? Would you say that you feel . . . ?**

Very safe

Somewhat safe

Neither safe nor unsafe

Somewhat safe

Very safe

**2. Do you have someone, either a family member or friend, who you could call during an emergency?**

No

Yes

**3. Would you need assistance evacuating your home during an emergency or natural disaster?**

No

Yes

**4. Do you have working smoke detectors in your residence?**

No

Yes

**5. Do you know about Voluntary Emergency Registry?**

No

Yes

**6. Are you currently listed on the registry?**

No

Yes

**7. Would you like more information about the registry so that you can be listed?**

No

Yes (Please contact: Central Oregon Council On Aging at (541)548-8817)

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

**8. Would you like a home safety check for fire/fall safety through our SOS (Safety Outreach for Seniors) program?**

No

Yes (Please contact: Central Oregon Council On Aging at (541)548-8817)

## 13. Volunteerism / Civic Engagement

**1. Are you a registered voter?**

No

Yes

**2. How often do you vote?**

Frequently

Occasionally

Rarely

Never

**3. Do you currently do any volunteer work?**

No

Yes

**4. How many total hours per month do you usually spend, including travel time, doing volunteer work?**

**5. Do you plan to volunteer or engage in your community in the future?**

No

Yes

**6. What types of volunteer activities most interest you? (Check all that apply)**

Services for seniors

Civic or social organization (including political)

Services for children or teens

Environmental organization

Hospital visiting or assistance

Philanthropic organization (Red Cross, food banks, etc.)

Religious organization

Not applicable

Museum or cultural organization

Other (please specify)

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 7. Within these activities, what tasks do you envision for yourself? (Check all the apply)

- Friendly visiting to homebound
- Fundraising
- Serving on board or advisory council
- Tutoring or mentoring
- Lobbying, political organization, advocacy
- Not applicable
- Counseling or peer support
- Maintenance
- Other (please specify)

## 14. Social Network / Social Support

### 1. What is a good name for the age group in which you belong?

- Seniors
- Golden agers
- Baby Boomers
- Elders
- Older Adults
- Lost generation
- Old Americans
- Mature Adults
- Refused to be labeled
- Other (please specify)

### 2. How do you cope with the cultural stigma of aging? (Check all that apply)

- I ignore it
- Get involved in AARP or other political interests groups
- Do medical enhancements/procedures (e.g. plastic surgery, botox)
- Move to a foreign country
- Invest in my community (volunteer)
- Join elder hostels
- Other (please specify)

### 3. Describe your sense of well-being?

- Very good
- Good
- Fair
- Poor
- Very poor

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 4. What are your sources of social support? (Check all that apply)

- Family
- Church groups
- Mentors
- Friends
- Spiritual groups
- Civic groups
- Pets
- Volunteering
- Don't have social support
- Residents in your living community
- Senior center
- Other (please specify)

## 5. Do you use your computer for social networking?

- No                                       Yes                                       Not applicable

## 15. Special questions for persons between 50-64 years old

If you are between the ages of 50-64 years old, please answer the following four questions.

If you are 65 years and older move on to Section 16.

### 1. Are there models for aging that you are ascribing/interested in? If not, how do you see yourself as aging in place?

### 2. Where do you see yourself thriving? (Check all that apply)

- Staying where you are
- Suburban areas
- Retirement community
- Moving near children/grandchildren
- Rural areas
- Senior apartments
- Moving in with your relatives
- Where you can afford it
- Urban areas
- Moving out of the country

### 3. What are the services you see yourself needing most to thrive? (Check all that apply)

- Economic/financial
- Housing
- Social
- Health
- Information about services
- Transportation

### 4. If you see yourself using a senior center, how do you see yourself using the facility?

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

## 5. How do you experience technology as impacting the quality of your life?

- I don't see it helping.
- I use it, but I don't really like it.
- I wish I could live my career over again-  
-I would be a techie!
- I hate technology, I wish it were the way it used to be--paper, pens and paperclips!
- I love it--it helps me stay connected to family and friends.

## 16. Special questions for persons 95 years and older

If you are 95 years and older please answer the following two questions.

If you are younger than 95 years old please move on to Section 17.

### 1. What do you feel are the reasons for your longevity? (Check all that apply)

- Genetics
- Taking care of your body
- Good social support
- Mental toughness
- Good stress management
- Reason to love
- Other (please specify)

### 2. What words of wisdom would you share with each of the following age groups?

20-39 year olds	<input type="text"/>
40-59 year olds	<input type="text"/>
60-80 year olds	<input type="text"/>

## 17. Feedback/Questions and Central Oregon Council On Aging Information

### 1. Any questions, comments, concerns, and/or suggestions you may wish to share with us?

# Central Oregon Council On Aging 2011 Senior Needs Assessment Survey

If you would like further information about:

- Case Management
- Congregate dining
- Meals on Wheels
- Respite caregiver program
- RSVP and/or Foster Grandparent (senior volunteer programs)
- SHIBA (Senior Health Insurance Benefits Assistance)
- S.O.S program (Safety Outreach for Seniors)
- Voluntary Emergency Registry

Please contact: Central Oregon Council On Aging  
1135 SW Highland Ave.  
Redmond, OR 97756  
Phone number: (541)548-8817  
Web: [www.councilonaging.org](http://www.councilonaging.org)

Thank you for taking the time to complete the survey. The information will help us develop services and programs designed to meet the current and future needs of Seniors.