**Please complete the survey only once**. You may skip any question that you do not understand or are not comfortable answering.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Right now, how concerned are you about:  | Not Concerned | Somewhat Concerned | Very Concerned | Not Applicable |
| Being able to live in your home as you get older |[ ] [ ] [ ] [ ]
| Being physically, emotionally or financially abused |[ ] [ ] [ ] [ ]
| Being the victim of a financial scam |[ ] [ ] [ ] [ ]
| Driving safely or not being able to drive |[ ] [ ] [ ] [ ]
| Falling or the fear of falling |[ ] [ ] [ ] [ ]
| Feeling lonely or being alone |[ ] [ ] [ ] [ ]
| Having enough money in retirement |[ ] [ ] [ ] [ ]
| Losing your memory or having dementia |[ ] [ ] [ ] [ ]
| Maintaining and repairing your home |[ ] [ ] [ ] [ ]
| Obtaining or understanding benefits (Social Security, Medicare, Medicaid) |[ ] [ ] [ ] [ ]
| Providing care to a spouse, partner or other loved one |[ ] [ ] [ ] [ ]
| Raising a grandchild or grandchildren |[ ] [ ] [ ] [ ]
| The amount of clutter or belongings in your home |[ ] [ ] [ ] [ ]

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| 2. How often do you: | Never | Sometimes | Often | Not applicable |
| Attend community activities or events |[ ] [ ] [ ] [ ]
| Depend on someone else to drive you somewhere |[ ] [ ] [ ] [ ]
| Feel lonely or isolated |[ ] [ ] [ ] [ ]
| Visit with friends or family |[ ] [ ] [ ] [ ]
| Volunteer in the community |[ ] [ ] [ ] [ ]

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| 3. Do you: | No | Yes | Not applicable |
| Actively move about or exercise daily |[ ] [ ] [ ]
| Eat fruits and vegetables daily |[ ] [ ] [ ]
| Go to the dentist at least once a year |[ ] [ ] [ ]
| Go to the doctor at least once a year |[ ] [ ] [ ]

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| 4. Do you have difficulty paying for:  | No | Yes | Not Applicable |
| Assistive devices (hearing aids, eye glasses) |[ ] [ ] [ ]
| Dental care including cleanings, extractions |[ ] [ ] [ ]
| Enough food to eat |[ ] [ ] [ ]
| Fresh/healthy food to eat (fruits, vegetables)  |[ ] [ ] [ ]
| Healthcare including doctor visits or hospitalizations |[ ] [ ] [ ]
| Medication  |[ ] [ ] [ ]
| Rent, mortgage or property taxes |[ ] [ ] [ ]
| Transportation (gas, insurance, repairs, public transit) |[ ] [ ] [ ]
| Utilities (heating, cooling, water) |[ ] [ ] [ ]

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| 5. How difficult is it for you to: | Not difficult | Somewhat difficult | Very difficult | Someone does this for me | Not applicable |
| Clean the house |[ ] [ ] [ ] [ ] [ ]
| Do the laundry  |[ ] [ ] [ ] [ ] [ ]
| Enter and/or exit your home  |[ ] [ ] [ ] [ ] [ ]
| Get dressed |[ ] [ ] [ ] [ ] [ ]
| Handle Paperwork/Pay Bills  |[ ] [ ] [ ] [ ] [ ]
| Manage your medication |[ ] [ ] [ ] [ ] [ ]
| Prepare a meal |[ ] [ ] [ ] [ ] [ ]
| Shop for groceries |[ ] [ ] [ ] [ ] [ ]
| Shovel snow or complete yard work  |[ ] [ ] [ ] [ ] [ ]
| Take a shower or bath |[ ] [ ] [ ] [ ] [ ]

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| --- | --- | --- | --- | --- | --- |
| 6. Please rate the following: | Poor | Fair | Good | Excellent | Prefer not to answer |
| Your overall physical health |[ ] [ ] [ ] [ ] [ ]
| Your overall mental health  |[ ] [ ] [ ] [ ] [ ]
| Your ability to live life with quality and dignity |[ ] [ ] [ ] [ ] [ ]
| Your community as a place to age well |[ ] [ ] [ ] [ ] [ ]
| Your overall oral health  |[ ] [ ] [ ] [ ] [ ]

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| Please tell us a little more about you: |
| 7. Where do you go for information about senior services and activities (check all that apply)? |
| [ ]  Prefer not to answer [ ]  Newspaper/Newsletters[ ]  My doctor [ ]  Local library [ ]  Faith community (churches) [ ]  Commission or Council on Aging[ ]  A family member or friend [ ]  Local senior center [ ]  Area Agency on Aging [ ]  Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Internet [ ]  I haven’t needed information |
| 8. How many times have you fallen in the last year? |
| [ ]  Prefer not to answer [ ]  No falls [ ]  1 – 2 falls [ ]  3 - 4 falls [ ]  5+ falls |
| 9. How many times have you used the Urgent Care or Emergency Room in the last year? |
| [ ]  Prefer not to answer [ ]  0 [ ]  1 [ ]  2 [ ]  3 [ ]  4 [ ]  5+  |
| 10. Your age group: [ ]  Prefer not to answer[ ]  Under 60 [ ]  60-64 [ ]  65-74 [ ]  75-84 [ ]  85+ |
| 11. Your gender: [ ]  Prefer not to answer [ ]  Male [ ]  Female [ ]  Prefer to self-describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 12. Are you employed? [ ]  Prefer not to answer[ ]  No [ ]  Yes (0-20 hours/week) [ ]  Yes (21-40 hours/week) |
| 13. Household income per year: [ ]  Don’t Know [ ]  Prefer not to answer |
| [ ]  $12,490 or less (1 person household)  | [ ]  $16,920 or less (2 person household)  |
| [ ]  More than $12,490 (1 person household)  | [ ]  More than $16,920 (2 person household)  |
| 14. Living arrangement: [ ]  Prefer not to answer |
| [ ]  Live alone [ ]  Live with significant other [ ]  Live with friends or relatives [ ]  Other |
| 15. What is your primary county of residence: [ ]  Prefer not to answer |
| [ ]  Allegan | [ ] Ionia  | [ ]  Kent | [ ]  Lake | [ ]  Mason |
| [ ]  Mecosta | [ ] Montcalm | [ ]  Newaygo | [ ]  Osceola | [ ]  Other |
| 16. What is your race/ethnicity (Select all that apply): [ ]  Prefer not to answer |
| [ ]  | American Indian or Alaska Native | [ ]  | Black or African American | [ ]  | Native Hawaiian or other Pacific Islander |
| [ ]  | White Hispanic | [ ]  | White Non-Hispanic | [ ]  | Other race/ethnicity |

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| **DO YOU PROVIDE CARE TO AN AGING OR ILL INDIVIDUAL?** **IF SO, PLEASE COMPLETE THESE QUESTIONS.** |  |
| **Please tell us about the care you provide to others.** |
| 1. Who do you provide care for (check all that apply)? |
| [ ]  Significant other | [ ]  Adult child with health conditions | [ ]  Aging parent(s) or in-law(s) |
| [ ]  Neighbor | [ ]  Friend | [ ]  Other relative |
| [ ]  Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 2. How much time do you spend caregiving each week? |
| [ ]  Less than 8 hours [ ]  8-20 hours [ ]  21-40 hours [ ]  41+ hours |
| 3. What types of care do you provide (check all that apply)? |
| [ ]  | House cleaning  | [ ]  | Lawn and snow care | [ ]  | Socialization |
| [ ]  | Bathing or dressing  | [ ]  | Home maintenance | [ ]  | Transportation |
| [ ]  | Meal preparation | [ ]  | Handling bills | [ ]  | Grocery shopping or errands  |
| [ ]  | Handling medications | [ ]  | Accompaniment to Medical Appointments  | [ ]  | Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 4. As a caregiver, what services are (or would be) most helpful (check all that apply)? |
| [ ]  | Adult day center | [ ]  | Help finding services | [ ]  | In-home respite care |
| [ ]  | Caregiver support groups | [ ]  | Financial planning for care needs | [ ]  | Planning for assisted living or nursing home care |  |
| [ ]  | Legal planning (wills, trusts, Power of Attorney, etc.) | [ ]  | Cleaning/meal preparation | [ ]  | Education about caregiving |
| [ ]  | Assistance to help with bathing and dressing | [ ]  | Planning for end of life (medical decisions, funeral arrangements) | [ ]  | Other (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **For further information about the topics listed above, please visit** [**https://www.aaawm.org/**](https://www.aaawm.org/) **or contact 1-888-456-5664 or 616-456-5664** |

**IF YOU HAVE COMPLETED THIS SURVEY AND ARE NOT SURE WHERE TO RETURN IT PLEASE CALL 1-888-456-5664 ATTN LACEY CHARBONEAU OR MAIL TO:**

**AAAWM, 3215 EAGLECREST DRIVE NE, GRAND RAPIDS, MI 49525**

**EMAIL:** **LACEYC@AAAWM.ORG**

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| --- |
| **To be entered in a drawing for prizes:** |
| Printed Name: | Phone: |