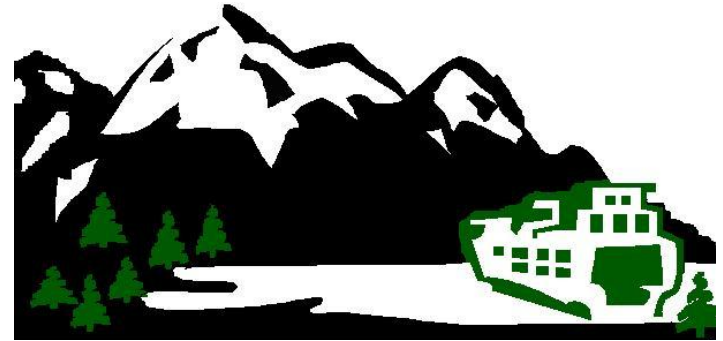


614 Division MS-5
Port Orchard, WA 98366

Kitsap County Aging & Long Term Care
614 Division MS-5
Port Orchard, WA 98366

WHAT WOULD
MAKE OUR
COMMUNITY
MORE
ELDER-FRIENDLY?

*A Community Needs Survey
for Older Adults or People with
Disabilities and their Caregivers*



Kitsap County Division of Aging
& Long Term Care
614 Division St., MS-5
Port Orchard, WA 98366
360.337.7068

YOUR OPINION COUNTS

The Kitsap County Division of Aging & Long Term Care...

- ◆ plans services for people who need personal care or assistance in their homes
- ◆ develops programs to provide those services
- ◆ advocates for the needs of older people, their families, and caregivers

You can help us to develop these programs and to advocate for the needs of people in our county.

But, because we don't personally know you, we prepared this booklet so you can tell us what our local community will need to be an excellent place that meets the needs of people who are older and people with disabilities.

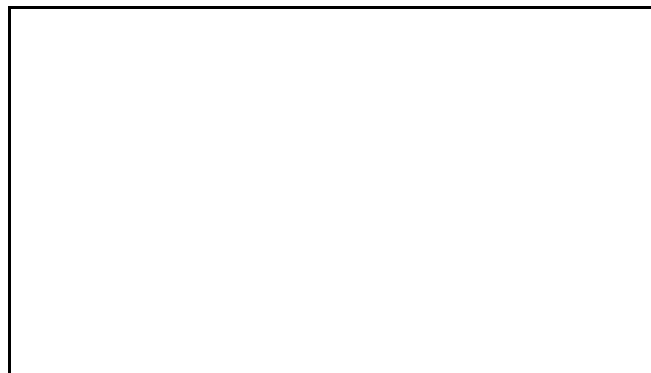
Please take just a few minutes to answer these questions, and return this booklet, either by giving it to the person who gave it to you, or by mailing it to the address on the back.

Your ideas are important to us and the people we serve. *Thank you for helping!*

***Please return by
June 30, 2007***

Thank you for completing our survey.

**As a token of our appreciation,
please remove the card attached
below and keep for your easy
reference.**



Are you caring for or helping a loved one? A caregiver is someone who provides in-home care, assistance with daily activities, or manages the care of a loved one at a distance. Support for unpaid caregivers who are helping someone to remain at home is available in Kitsap County.



Caregiver Support Center
 360-337-5700
 1-800-562-6418
 9729 Silverdale Way NW
 (Silverdale Community Center)
 Kitsap County Aging & Long Term Care Services

The Caregiver Support Center Offers:

- ◆ Caregiver Respite
- ◆ Information & Education
- ◆ Support Groups
- ◆ Specialized Services

Without support, caregivers tend to neglect their own health and well-being resulting in extreme stress, physical health problems, depression, and feelings of anger and anxiety.

“Take care of yourself while taking care of your loved one.”



Kitsap County Aging & Long Term Care Services



Advocacy. Action. Answers on Aging

Kitsap County's Area Agency on Aging

✂ Cut here and save this page for your easy reference. ✂

TELL US ABOUT YOUR BASIC NEEDS

(or the person you are responding for)

Note: Because we do not know your name, your responses to these questions are completely confidential. The information you provide will be used for program planning purposes only.

Thank you for your assistance!

1. My neighborhood is a good place to live.

Yes No

 If no, why?

2. I feel safe in my neighborhood.

Yes No

 If no, why?

3. If I became disabled, I could continue to live in my home.

Yes No

 If no, why?

4. Have you or someone you know ever been the victim of:

- Mental Abuse
- Physical Abuse
- Neglect
- Financial Exploitation

If yes, did you or the person you know get help?

- Yes No

If yes, were you or the person you know satisfied with the assistance received?

- Yes No

5. I spend this much of my income on housing:

- Half or more. More than one third.
- One third or less. Nothing.

6. If I sometimes don't eat properly it is because: *(check all that apply)*

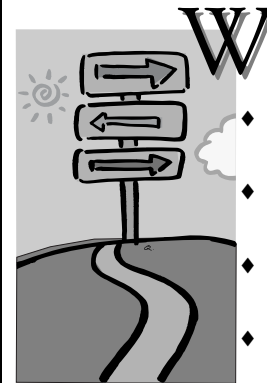
- I can't afford to buy food
- I can't get out and go to the store
- I don't know what I should eat
- I have trouble preparing proper foods
- Other (specify) _____

✂ Cut here and save this page for your easy reference. ✂

When you have questions about aging and available senior services, Kitsap County's Senior Information & Assistance is here to help. Senior Information & Assistance provides professional consultation and access to social and health services to help seniors live safely, with dignity, in the least restrictive way.

Senior Information & Assistance

A **FREE** service for seniors age 60 and over
360-337-5700 or 1-800-562-6418



Where to turn in Kitsap County for:

- ◆ **Answers** to questions about services & opportunities
- ◆ **Assessment** of needs & referral to local services
- ◆ **Assistance** finding & applying for programs & services
- ◆ **Advocacy** on important senior issues

"Promoting the well being of older people and assisting them in maintaining their independence."



Kitsap County Aging
& Long Term Care Services



Kitsap County's
Area Agency on Aging

Thank you for your comments. If you, or someone you know, needs help or information about services for older people and people with disabilities, please don't hesitate to add your comments here, or call Senior Information & Assistance at 1-800-562-6418. Or give us your contact information below and we will contact you.



7. If I needed help with my basic needs and activities, I would call: *(check all that apply)*

- My friends and family
- My church
- A social service agency
- My doctor
- I don't know
- Other (specify) _____

8. I have enough help with my basic needs.

- Yes No Don't need help

Basic needs are: ambulating, bathing, bed mobility, body care, dressing, eating, foot care, medication management, personal hygiene, toileting and transferring.

9. If available in your area, would you participate in an out-of-home Adult Day Services program that provides companionship, meal preparation, supervision, special activities and personal care?

- Yes No

If no, why?

TELL US ABOUT YOUR HEALTH

1. I am up-to-date with my medical screening and health care. *(check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Eye Tests | <input type="checkbox"/> Vaccinations |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Medication Review | <input type="checkbox"/> Colonoscopy |
| <input type="checkbox"/> Bone Density | <input type="checkbox"/> Cholesterol |
| <input type="checkbox"/> Hearing Test | <input type="checkbox"/> Mammogram |
| <input type="checkbox"/> Breast Self-exam | <input type="checkbox"/> Prostate Exam |
| <input type="checkbox"/> Skin Exam | <input type="checkbox"/> Dental Exam |

2. I exercise at least 30 minutes on most days of the week.

- Yes No

If no, why?

3. When I exercise I usually: *(check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Walk or hike | <input type="checkbox"/> Run or jog |
| <input type="checkbox"/> Lift weights | <input type="checkbox"/> Tai Chi |
| <input type="checkbox"/> Yoga | <input type="checkbox"/> Chair Exercise |
| <input type="checkbox"/> Swim/Water Exercise | <input type="checkbox"/> Dance |
| <input type="checkbox"/> Ride a bike | <input type="checkbox"/> Ski |
| <input type="checkbox"/> Other (specify) _____ | |

TELL US YOUR SUGGESTIONS

What would you think would make your community more elder friendly?

Service	Important?		
	Very	A Bit	Not
Wider Streets; Larger Signage			
Safer Sidewalks (even; well-lit)			
Pedestrian Crossing Lights			
Benches on Pathways/Sidewalks			
More Public Transportation			
More Affordable Housing			
More Accessible Housing			
Free Health Screening			
Employment Opportunities			
Low Cost Exercise/Recreation			
Food Bank			
Improved Healthcare Access			
Enhanced Public Safety			
Volunteer Opportunities			
Senior Block Watch			
Other:			

TELL US ABOUT SERVICES

Please mark an X in the boxes below that describe services that you have used or might need.

Service	I've Used & I		I think I	
	Liked	Dis-liked	Might Need	Won't Need
Senior Lunches (out of home)				
Meals on Wheels (in home)				
Adult Day Care/Services				
Respite Care				
Caregiver Support				
Special Transportation				
Help with Personal Care				
Case Management				
Home Modifications				
Health Screenings				
Depression Screenings				
Health Education				
Food Bank				
Fitness Classes				
Housing Assistance				
Legal Help				
Adult Protective Services				
Information & Assistance				

4. I eat this many servings of fruits and vegetables most days of the week.

- Less than 3 3-4
 5-7 8-9

If you eat less than 3 servings per day, why?

5. I consider my health to be :

- Excellent Good
 Fair Poor

6. My health limits what I can do. Yes No

7. I have trouble falling asleep, staying asleep, or sleeping too much.

- Often Sometimes Rarely Never

8. I feel tired or have little energy.

- Often Sometimes Rarely Never

9. I feel sad or blue.

- Often Sometimes Rarely Never

10. I have seen a doctor for depression. Yes No

11. I have fallen in the last 12 months. Yes No

12. I am worried about falling down. Yes No

MORE ABOUT YOUR HEALTH...

13. I don't always go to the doctor when I should because: *(check all that apply)*

- I cannot afford to pay
- I have no transportation
- I cannot find anyone who will take my insurance
- I always go when I should
- Other (specify) _____

14. Medicare covers all or most of my medical expenses.

- Yes No Does not apply

15. Medicare Part D has saved me money on my medications.

- Yes No Don't know
- I didn't sign up for Medicare Part D.

16. I don't always go to the dentist when I should because: *(check all that apply)*

- I cannot afford to pay
- I have no transportation
- I cannot find anyone who will take my insurance
- I always go to the dentist when I should
- Other (specify) _____

6. Have you ever received services from a senior or community service program? (Volunteer Services, Senior Meals, Information & Assistance, etc.)

- Yes No

If your answer was "Yes," in which program(s) have you participated?

7. Where do you live?

- | | |
|--|---|
| <input type="checkbox"/> Bainbridge Island | <input type="checkbox"/> Silverdale |
| <input type="checkbox"/> Bremerton | <input type="checkbox"/> North Kitsap |
| <input type="checkbox"/> Port Orchard | <input type="checkbox"/> Central Kitsap |
| <input type="checkbox"/> Poulsbo | <input type="checkbox"/> South Kitsap |

8. Do you live within city limits?

- Yes No

9. What is your zip code? _____



TELL US ABOUT YOURSELF
(or the person you are responding for)

1. Age: under 50 50-59 60-64
 65-74 75-84 85+
2. Sex: Male Female
3. Ethnicity:
 Asian or Pacific Islander African American
 Native American Indian Hispanic
 Caucasian/White Other (specify) _____
4. How many people (including you) live in your household? _____
5. What is your usual household income per month?
 \$850 & Under \$851 - \$1,132
 \$1,133 - \$1,276 \$1,277 - \$1,574
 \$1,575 - \$2,127 \$2,128 & Over
6. Are you a grandparent/other relative providing primary care to one or more children ?
 Yes No
If yes, are they 18 years of age or younger?
 Yes No
If yes, do they live with you?
 Yes No

17. I don't maintain my correct denture fit because:
(check all that apply)
 I cannot afford new dentures
 I cannot afford to fit my dentures
18. The healthcare system in my community is very good for older people.
 Yes No
If no, why not?

19. I take _____ medicines on a regular basis.
(number)
20. I take nutritional supplements, vitamin pills, or herbal remedies regularly.
 Yes No
21. When the doctor gives me a prescription: *(check all that apply)*
 I get it filled and take it as I should
 I don't take my medicine as I should because
 I forget I can't afford it
 I review all of my medicines with a pharmacist
 I ask my doctor about side effects
 Other (specify) _____

22. I always carry a list of all of my medications.
 Yes No
23. I experience pain which limits my daily activities on a regular basis.
 Yes No
24. I sometimes drink alcohol.
 Yes No
25. I sometimes drink a little too much alcohol.
 Yes No
26. I sometimes drink and skip my medication since that might be a bad combination.
 Yes No
27. I drink alcohol and sometimes worry I might have a problem.
 Yes No



TELL US ABOUT YOUR EMERGENCY PREPAREDNESS

1. Do you have a plan for your household in case of an emergency?
 Yes No
2. Would you be able to evacuate from your home in the event of a disaster?
 Yes No
3. Do you have enough supplies, medicine, and a source of heat in case you have to shelter in your home for three days without electricity?
 Yes No
4. Do you have neighbors, friends, or family who would assist you in an emergency or disaster?
 Yes No
5. In an emergency, where would you go to get information? *(check all that apply)*
- | | |
|------------------------------------|--|
| <input type="checkbox"/> Radio | <input type="checkbox"/> Television |
| <input type="checkbox"/> Computer | <input type="checkbox"/> Family/Neighbors |
| <input type="checkbox"/> Newspaper | <input type="checkbox"/> Other publication |
6. Do you have an out-of-state emergency contact?
 Yes No
7. Do you have at least one (1) non-cordless phone?
 Yes No

7. I feel safe in the crosswalks in my community.

Yes No

8. Does your community have pedestrian signals?

Yes No

If yes, do the signals allow enough time to safely cross the street?

Yes No

9. Street signs in my community are easy to read and understand.

Yes No

10. I use the following public recreation opportunities: *(check all that apply)*

Parks Senior Center

Beaches Pool

Trails Gymnasium

Other (specify) _____

11. I cannot use public recreation opportunities because: *(check all that apply)*

No Transportation Not Accessible

Afraid/ Not Safe No Interest

Not physically able to use them

Other _____

TELL US ABOUT YOUR INDEPENDENCE

1. I have a disability which limits one or more of my usual daily activities. Yes No

2. I am able to drive my car or get around on my own. Yes No

3. I have access to public transportation like busses or ferries. *(if no, go on to question five)*
 Yes No

4. I use public transportation.
 Yes No

If no, why? *(check all that apply)*

I don't know how

It takes too long

I might get lost

I don't feel safe

It is not convenient

I can't manage physically

Other (specify) _____

5. I can do these by myself, or have enough people to help me. *(check all that apply)*

- | | |
|--------------------------------------|---|
| <input type="checkbox"/> Walk | <input type="checkbox"/> Travel to appointments |
| <input type="checkbox"/> Eat | <input type="checkbox"/> Take my medicine |
| <input type="checkbox"/> Take a bath | <input type="checkbox"/> Dressing/Grooming |
| <input type="checkbox"/> Cook | <input type="checkbox"/> Manage my money |
| <input type="checkbox"/> Clean house | <input type="checkbox"/> Stand up and sit down |

6. I help another person with the activities listed above.

- Yes No *(if no, go to next page.)*

If yes, I get a chance to take a break and get a rest from my caregiving.

- Yes No

7. As a caregiver, the following are important to me: *(check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Training | <input type="checkbox"/> Adult Day Services |
| <input type="checkbox"/> Support groups | <input type="checkbox"/> A rest once in a while |
| <input type="checkbox"/> Counseling | <input type="checkbox"/> Help with chores |
| <input type="checkbox"/> Planning for the future | |
| <input type="checkbox"/> Other (specify) _____ | |

TELL US ABOUT YOUR COMMUNITY

1. I regularly attend church, temple, or other spiritual gatherings.
 Yes No
2. I have attended one sports, community, club, cultural, social, or family event in the past week.
 Yes No
3. I volunteer regularly.
 Yes No
4. People in my community are willing to help me if I need help.
 Yes No
5. If I wanted to work for pay, I would be able to find someone to hire me.
 Yes No
6. The sidewalks in my community are safe.
 Yes No

