

County Needs Assessment

Sponsored By CHANGE, Inc. Community Action Agency

1. What county do you live in? Hancock Brooke Ohio Marshall Other: _____

2. Check if the following are needs for you or your family.

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Medical Healthcare | <input type="checkbox"/> Clothing | <input type="checkbox"/> Housing Loans | <input type="checkbox"/> Legal Services |
| <input type="checkbox"/> Dental Healthcare | <input type="checkbox"/> Food | <input type="checkbox"/> Housing Repairs | <input type="checkbox"/> Utilities |
| <input type="checkbox"/> Vision Healthcare | <input type="checkbox"/> Job Transportation | <input type="checkbox"/> Employment | <input type="checkbox"/> Counseling |
| <input type="checkbox"/> Prescriptions | <input type="checkbox"/> Medical Transportation | <input type="checkbox"/> Education | <input type="checkbox"/> Domestic Violence Services |
| <input type="checkbox"/> Mental Healthcare | <input type="checkbox"/> Housing | <input type="checkbox"/> Childcare | <input type="checkbox"/> Income Tax Preparation |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Disability Assistance | <input type="checkbox"/> Elder Care | <input type="checkbox"/> Senior Services |

3. Please list any additional needs you or your family has that were not listed above.

4. Check how much of a problem the following barriers are to you and your family in seeking/gaining assistance with your basic needs.

Barrier	Not A Problem	Somewhat Of A Problem	A Big Problem
Can't Afford Fees/Costs of Assistance			
Not Eligible/Don't Qualify For Assistance			
No Transportation To/For Assistance			
Don't Know Where To Go For Help			
Pride (Don't Want To Ask For Help)			
Programs/Services Not Available in My Area			
No Childcare While Receiving/Obtaining Assistance			
Prior Bad Experience With Service/Program			
Have To Work During Service Hours			
Health/Disability			

5. How many children do you have? _____ Living In Household? _____

6. Are you a single parent? YES NO

7. What are your barriers to childcare services? (Check All That Apply)

- | | | |
|---|--|---|
| <input type="checkbox"/> No Barriers | <input type="checkbox"/> Children Have Special Needs | <input type="checkbox"/> Not Enough Childcare Providers |
| <input type="checkbox"/> Cost | <input type="checkbox"/> Location of Childcare Providers | <input type="checkbox"/> Quality of Childcare Providers |
| <input type="checkbox"/> Hours Not Sufficient | <input type="checkbox"/> No Transportation | |

8. How many household members do NOT currently have health insurance? (Including Medicare, Medicaid, CHIP, Private Insurance) (Please Circle)

1 2 3 4 5 6 7 8 or more

9. Of those with NO health insurance, how many are: Under 18: _____ Over 65: _____

10. What are your barriers to health care? (Check All That Apply)

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> No Barriers | <input type="checkbox"/> No Insurance | <input type="checkbox"/> No Doctor in My Area |
| <input type="checkbox"/> Cost | <input type="checkbox"/> No Transportation to Doctor | <input type="checkbox"/> No Childcare During Appointment |

11. Were you able to receive dental care in the last year? YES NO

12. Why did you not receive dental care in the last year? (Check All That Apply)

- | | | |
|---------------------------------------|------------------------------------|--|
| <input type="checkbox"/> No Insurance | <input type="checkbox"/> My Choice | <input type="checkbox"/> No Transportation |
| <input type="checkbox"/> Cost | <input type="checkbox"/> Fear | <input type="checkbox"/> No Childcare During Appointment |

PLEASE TURN OVER TO COMPLETE SURVEY.

13. What is your Employment Status?

- Full-time Part-time Unemployed/Not Searching
 Full-time with benefits Part-time with benefits
 Retired Unemployed/Job Searching

14. What are your barriers to employment? (Check All That Apply)

- No Barriers Pay Too Low To Support Family Lack of Training or Experience
 No Jobs For My Field No Childcare During Work Mental Disability
 No Transportation Physical Disability

15. Do you have reliable Transportation? YES NO

16. What are your barriers to reliable transportation? (Check All That Apply)

- No Barriers Price of Gas No Routes Near Home
 No Car/Can't Afford Car No Private Transportation No Routes Near Work
 No Public Transportation

17. Are your housing conditions adequate? YES NO

18. Do you own your home? YES NO

19. Type of residence?

- Rental Unit Home With Mortgage Shelter
 Home You Own With Family/Friends Homeless

20. What are your major housing concerns? (Check all that apply)

- Rent too high Utilities too high Can't find house in price range
 House needs major repairs Can't afford house payments No Concerns

21. Check if you HAVE a:

- Phone Computer Internet Access

22. Have you ever used one of CHANGE, Inc.'s services? YES NO

23. Please circle the appropriate response under each demographic heading.

AGE	MARITAL STATUS	RACE	GENDER	NUMBER IN HOUSEHOLD	HOUSEHOLD INCOME
Under 20	Singe	Black/African American	Male	1	No income
20-24	Married	White/Caucasian	Female	2	Less than 10,000
25-39	Divorced	Asian		3	10,001 – 20,000
40-59	Widowed	Bi-Racial/Multi-Racial		4	20,001 – 30,000
60-64	Separated	American Indian		5	30,001 – 40,000
65-79		Alaska Native		6	40,001 – 50,000
Over 80				7	50,001 – 60,000
				8 or more	60,001 – 70,000
					Above 70,000

24. Circle The Highest Level of Education You Have Completed.

- Some Grade School Some Technical School Completed College/Bachelor Degree
 Completed Grade School Completed Technical School Master's Degree
 Some High School Some College Doctorate Degree
 Completed High School Completed College/Associate Degree

THANK YOU FOR YOUR TIME. PLEASE RETURN TO SURVEY BOX.