



2024 Older Adult and Adult with Disabilities Needs Assessment Survey

Section 1. Introduction

The Rogue Valley Council of Governments is the Area Agency on Aging for Jackson and Josephine Counties. The Senior and Disability Services and Senior Nutrition Departments serve older adults and adults with disabilities and every four years conduct an assessment of area needs. We encourage you to share your experience and opinions with us by completing this survey. Your input will assist us in planning for the future needs of older adults and adult with disabilities. We will use the information you provide to prioritize programs, services, and supports in our Strategic Plan period of 2025-2029.

This survey should take approximately 15 minutes of your time to complete. No identifying information is being collected and your responses are confidential. At the conclusion of the survey, you will be asked if you would like to participate in a drawing for a \$50 VISA gift card. **This survey closes on March 1, 2024.** We greatly appreciate your input!

Online link: <https://www.surveymonkey.com/r/PXTFY98>

Or use this QRCode:



Please feel free to forward the link or QR code to others who may have valuable insights to share.

If you have any questions regarding this survey, please contact:

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Senior and Disability Services
Rogue Valley Council of Governments
155 N. 1st Street
P. O. Box 3275 (for all mail)
Central Point, OR 97502
541-423-1373
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7. Do you receive assistance with transportation?

- Yes No

8. If yes, who currently assists you with transportation? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Family | <input type="checkbox"/> Rogue Valley Transportation District (Bus) |
| <input type="checkbox"/> Friend(s) | <input type="checkbox"/> Valley Lift |
| <input type="checkbox"/> Call-A-Ride | <input type="checkbox"/> Taxi/Uber/Lyft |
| <input type="checkbox"/> Josephine Community Transit | <input type="checkbox"/> Volunteer(s) |
| <input type="checkbox"/> Josephine County Dial-A-Ride | <input type="checkbox"/> Private Pay – Non-Emergency Medical Transit |
| <input type="checkbox"/> Other (please specify): _____ | |

9. Do you miss activities because of transportation issues?

- Frequently Sometimes Never

Section 5. Sources of Information and Assistance

10. 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 information about services or resources? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> AARP | <input type="checkbox"/> newspaper/radio/TV |
| <input type="checkbox"/> Aging & Disability Resource Connection (ADRC) | <input type="checkbox"/> Phone book/yellow pages |
| <input type="checkbox"/> Church/faith community | <input type="checkbox"/> Resource guide |
| <input type="checkbox"/> Community resource tables at events | <input type="checkbox"/> Senior center |
| <input type="checkbox"/> County or state offices | <input type="checkbox"/> Social Media |
| <input type="checkbox"/> Family/friends/neighbors | <input type="checkbox"/> Nextdoor (online community) |
| <input type="checkbox"/> Hospital/medical provider/clinic | <input type="checkbox"/> Community or Cultural Center |
| <input type="checkbox"/> Internet/computer | <input type="checkbox"/> Meal or Food Delivery Program |
| <input type="checkbox"/> Library | <input type="checkbox"/> 211 Call Center |
| <input type="checkbox"/> Caseworker | <input type="checkbox"/> I don't know who to ask |
| <input type="checkbox"/> Other (please specify): _____ | <input type="checkbox"/> I would not contact anyone |

11. If you have used the Aging and Disability Resource Connection (ADRC), overall how helpful was the service?

- | | |
|---|---|
| <input type="checkbox"/> Extremely helpful | <input type="checkbox"/> Slightly helpful |
| <input type="checkbox"/> Very helpful | <input type="checkbox"/> Not at all helpful |
| <input type="checkbox"/> Moderately helpful | <input type="checkbox"/> Haven't used ADRC |

Section 6. Health and Wellbeing

12. How would you rate your physical health?

- Excellent Fair
 Good Poor

13. How would you rate your quality-of-life life?

- Excellent Fair
 Good Poor

14. Do you feel socially isolated?

- Yes No Uncertain

15. Do you experience feelings of loneliness?

- Yes No Uncertain

16. Are you able to afford all of your prescriptions?

- Yes No Don't know

17. Do you have an advance directive?

- Yes No Don't know

18. Do you have a POLST (Portable Medical Order)?

- Yes No Don't know

19. What health services are you NOT accessing that you need? (Check all that apply)

- Alternative Health Eye Care Provider
 Dentist Mental Health
 Doctor Physical / Occupational Therapy

20. What are the barriers you experience to accessing medical services? (Please specify)

21. Have you had difficulty finding a: (Check all that apply):

- Primary Health Care Provider
 Specialist
 Mental Health Provider
 Dental provider
 Other (please specify): _____

22. Have you been unable to go to a health care provider because they do not accept Medicaid / Oregon Health Plan (OHP) ?

Yes No Not applicable

23. Have you been unable to go to a health care provider because they do not accept your Medicare or Medicare Advantage Plan?

Yes No Not applicable

24. Do you have annual physical checkups? Yes No

25. Have you had health screening procedures done for the following conditions within the last five years? (Check all that apply)

- Heart disease
- High or low blood pressure
- Colorectal cancer
- Diabetes
- Breast cancer (mammogram)
- Prostate cancer
- Mental health screening

26. Have you had the following vaccination in the last year? (Check all that apply)

- Flu
- RSV
- Shingles
- COVID19
- Pneumonia

27. Are you aware that Medicare benefits may cover all or some portion of health screenings and vaccinations?

Yes No

28. Please rate how concerned you feel currently about each of the following: (Check all that apply)

	Not concerned	A little concerned	Somewhat concerned	Very concerned
I am concerned about having enough money to live on.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about being healthy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about having enough to eat.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned I will have to depend on other people.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned I will lose my home (ex: financial).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not concerned	A little concerned	Somewhat concerned	Very concerned
I am concerned I will have to leave my home.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about being lonely and without friends.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about being the victim of crime.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am concerned about losing my memory.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other Concerns (Specify)				

29. During the past year, have you utilized any of the following programs for food? (Please check all that apply)

- Senior Meal Sites'
- Home Delivered Meals
- Supplemental Nutrition Assistance Program (SNAP)
- Food Pantry
- Free Farmer's Markets
- Other (please specify) _____

Section 7. Caregiving and Care Receiving

30. Do you currently provide care for: (please check all that apply)

- An aging loved one
- Parent
- Adult with a disability
- Child
- Other (please specify)
- Grandchild
- Spouse/Significant Other
- Friend
- Neighbor

31. If you currently provide care for another, please share the number of unpaid hours you provide care in an average week:

- Up to 8 hours per week
- 9 to 19 hours per week
- 20 to 39 hours per week
- 40 or more hours per week

32. Does a relative, friend or family member currently help you with tasks?

- Yes No

33. If you currently receive care from another, please share the number of hours you receive unpaid care in an average week:

- Up to 8 hours per week
 9 to 19 hours per week
 20 to 39 hours per week
 40 or more hours per week

34. If you currently receive care from another, please share the number of hours you receive paid care in an average week:

- Up to 8 hours per week
 9 to 19 hours per week
 20 to 39 hours per week
 40 or more hours per week

35. If you receive paid care, which is the source of funding? (Check all that apply)

- Private pay
 Public funding
 Insurance

36. Do you have enough help with tasks?

- Yes No

37. If you are not able to receive the amount of care needed, which of the following apply? (Check all that apply)

- Insufficient number of caregivers in my area
 I don't understand how to hire a caregiver
 Prior negative experience with a caregiver
 I don't feel comfortable asking for help
 Safety concerns
 Other, please specify: _____

38. If no, which tasks do you need help with? (Check all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Housekeeping |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Shopping |
| <input type="checkbox"/> Personal Hygiene/Grooming | <input type="checkbox"/> Meal Preparation |
| <input type="checkbox"/> Dressing/Grooming | <input type="checkbox"/> Medication Management |
| <input type="checkbox"/> Elimination | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Cognition | |
| <input type="checkbox"/> Mobility/Ambulation/Transfers | |

Section 8: Housing

39. Do you prefer to live in your current home for as long as you safely can?

Yes No

40. Do you have a plan for where you will live as you age?

Yes No

If you rent, answer questions 41 and 42.

41. Have you had trouble finding an affordable rental recently?

Yes No

42. Are you currently on the list for rental assistance?

Senior housing Section 8 housing How long? _____

If you own your own home, answer questions 43.

43. Is the cost of keeping and maintaining your house a challenge for you?

Yes No

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

Yes No Not applicable

45. If yes, what modifications are needed at your current residence?

Modification Needed	No/Yes?	Are you planning to make this change? No/Yes/Not applicable?
Better cooling in the summer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Better heating in the winter	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Weatherization such as insulation and double-pane windows	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Easier access into or within your home such as a ramp, chair lift, clearance for wheelchair, or elevator	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Working kitchen appliances	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable

Modification Needed	No/Yes?	Are you planning to make this change? No/Yes/Not applicable?
Bathroom modifications such as grab bar, handrails, a high toilet, or nonslip tile	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Elimination of problems with insects, rodents, or other pests	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Structural changes or major repairs such as new roof or new plumbing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable
Changes to keep smoke out of the living space during fire season.	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not applicable

46. Please specify the major reason for not planning to make the modifications listed in

Question 35:

- | | |
|--|--|
| <input type="checkbox"/> Can't afford it | <input type="checkbox"/> Don't trust anyone to do it |
| <input type="checkbox"/> Can't find information to make the change | <input type="checkbox"/> Not sure will still be in residence |
| <input type="checkbox"/> Can't do it myself | <input type="checkbox"/> Not real need |
| <input type="checkbox"/> Can't find contractor/workers/others to do it | <input type="checkbox"/> I can't make the change, I am renting |
| <input type="checkbox"/> Can't get to hardware or supply store | |
| <input type="checkbox"/> Other (please specify): _____ | |

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

Section 9: Disaster Preparedness

48. Do you have someone, a family member or friend, living nearby who would help you during an emergency (fire, flood, earthquake, etc.?)

- Yes No

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

- Yes No

50. The Disaster Registry is something you can sign up with if you think you would need help in getting to a safe place during an emergency. Do you know about the Disaster Registry?

Yes No I am listed in the Disaster Registry

51. Would you like more information about the Disaster Registry so that you can be listed?

Yes No

If yes, please contact Senior and Disability Services of the Rogue Valley Council of Governments at 541-423-1373 or visit www.RVCOG.org.

Section 10: Services

52. Below is a listing of some of the services that are available in the Rogue Valley. Check all that you are aware of or have used.

Service	I am aware of	I have used
Adult Protective Services	<input type="checkbox"/>	<input type="checkbox"/>
Care Settings (Adult Foster Homes, Assisted Living Facilities, Residential Care Facilities, Skilled Nursing Facilities, Hospice)	<input type="checkbox"/>	<input type="checkbox"/>
Caregiver Training and Support	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Disease / Pain / Diabetes Self Management	<input type="checkbox"/>	<input type="checkbox"/>
Driver Safety Training	<input type="checkbox"/>	<input type="checkbox"/>
Dementia Support Programs	<input type="checkbox"/>	<input type="checkbox"/>
Financial Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Guardianship / Conservatorship	<input type="checkbox"/>	<input type="checkbox"/>
Heating and Utility Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Home Care	<input type="checkbox"/>	<input type="checkbox"/>
Personal Care	<input type="checkbox"/>	<input type="checkbox"/>
Home-Delivered Meals	<input type="checkbox"/>	<input type="checkbox"/>
Senior Meal Sites	<input type="checkbox"/>	<input type="checkbox"/>
Housing Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Legal Assistance	<input type="checkbox"/>	<input type="checkbox"/>

Service	I am aware of	I have used
Medical Supplies	<input type="checkbox"/>	<input type="checkbox"/>
Medicare Information	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Counseling Services	<input type="checkbox"/>	<input type="checkbox"/>
SNAP (Food Stamps)	<input type="checkbox"/>	<input type="checkbox"/>
Support Groups (such as Alzheimer's, Grief)	<input type="checkbox"/>	<input type="checkbox"/>
Tax Preparation Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>
Home Modifications	<input type="checkbox"/>	<input type="checkbox"/>
Prescription Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Risk Assessments	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Services	<input type="checkbox"/>	<input type="checkbox"/>

53. Please list other services that you wish were available in Jackson or Josephine Counties.

1 _____

2 _____

3 _____

4 _____

5 _____

Section 11: Demographics

54. What is your age: _____

Continue to Next Page, Please

55. What is your racial or ethnic identity?

- | | |
|---|---|
| <input type="checkbox"/> Asian | <input type="checkbox"/> Multi Racial |
| <input type="checkbox"/> African | <input type="checkbox"/> Native Hawaiian/Other Pacific Islander |
| <input type="checkbox"/> American Indian/Alaskan Native | <input type="checkbox"/> Slavic |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> White |
| <input type="checkbox"/> Latino/Hispanic | <input type="checkbox"/> Middle Eastern |
| <input type="checkbox"/> Other (please specify) _____ | |

56. Do you identify as: (check one)

- | | |
|---|--|
| <input type="checkbox"/> Heterosexual/Straight | <input type="checkbox"/> Asexual |
| <input type="checkbox"/> Lesbian | <input type="checkbox"/> Same gender loving |
| <input type="checkbox"/> Gay | <input type="checkbox"/> I don't know what this question is asking |
| <input type="checkbox"/> Bisexual | <input type="checkbox"/> I do not want to answer |
| <input type="checkbox"/> Pansexual | |
| <input type="checkbox"/> Queer | |
| <input type="checkbox"/> Not listed, please specify _____ | |

57. How do you currently describe yourself? (check one)

- Male
- Female
- Non-binary/Agender
- Intersex
- Transgender Male
- Transgender Female
- Not Listed, please specify: _____
- I don't know what the question is asking
- I do not want to answer

58. When you were born, what sex was assigned to you?

- | | |
|---|--|
| <input type="checkbox"/> Male | <input type="checkbox"/> Don't know |
| <input type="checkbox"/> Female | <input type="checkbox"/> I do not want to answer |
| <input type="checkbox"/> Intersex | |
| <input type="checkbox"/> Not listed, please specify _____ | |

Continue to Next Page, Please

59. Functional Disabilities

Your answers will help identify health and service differences among people with and without functional difficulties.

	Yes	No	Don't know	Don't want to answer	Don't know what this question is asking
Are you deaf or do you have serious difficulty hearing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	Don't know	Don't want to answer	Don't know what this question is asking
Are you blind or do you have serious difficulty seeing, even when wearing glasses?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have serious difficulty walking or climbing stairs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty dressing or bathing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have serious difficulty learning how to do things most people your age can learn?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No	Don't know	Don't want to answer	Don't know what this question is asking
Using your usual, (customary) language, do you have serious difficulty communicating (for example understanding or being understood by others)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Because of a physical, mental or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have serious difficulty with the following: mood, intense feelings, controlling your behavior, or experiencing delusions or hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a hidden or invisible disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

60. Are you retired?

- Yes No I choose not to answer

Continue to Next Page, Please

61. Please indicate your monthly income:

- \$608 and under
- \$609 to \$1215
- \$1216 to \$1823
- \$1824 to \$2430
- \$2431 and over

62. Are you a Veteran?

- Yes
- No
- I choose not to answer

63. What is the primary language spoken at home?

- English
- Spanish
- Other, please specify _____

64. All who complete the survey are eligible to participate in a drawing for a \$50 VISA gift card. If you would like to take part in the drawing, please complete the following:

Name _____
Address _____

Email _____

THANK YOU FOR COMPLETING THIS SURVEY!

Your responses will be very helpful to us as we make plans to better serve you and our community in the Rogue Valley

Please return the completed survey to:

*LeAnne Turnbull
RVCOG
P. O. Box 3275
Central Point, OR 97502*