DELAWARE COUNTY OFFICE FOR THE AGING

NY Connects
Your Link to Long Term Services and Supports

97 Main Street, Suite #2; Delhi, New York 13753

Phone: 607-832-5750 **WebSite:** www.co.delaware.ny.us/departments/ofa/ofa.htm
Fax: 607-832-6050 **E-mail:** ofa@co.delaware.ny.us **Director:** Wayne Shepard

Dear Delaware County Resident,

As a valuable member of our community, Delaware County Office for the Aging is interested in hearing what you have to say about what is important to you about living in Delaware County. Our mission is to help make Delaware County a great place for older adults. Specifically, we're interested in what is important to you in order to live here in Delaware County, safely and happily.

We would like your help in determining the services that are important to enabling you to live independently in your community. Nationwide, the cost of assisted living is now over $20,000 per year, and care in a skilled nursing facility is around $90,000 annually. In communities where services are not readily available, nursing homes may be able to do so, with various kinds of supports in place.

Our hope is that you will assist us in determining what kinds of services are important and necessary in our community to support our residents as they age, by taking a moment to complete the brief survey that is attached.

At the end of the survey, there are some personal questions that will assist us in planning, but we assure you that we will not know who returned the survey, and your identity will not be known to us, unless you share that information so that we may contact you with information.

It will be a small but important gesture on your part toward supporting our efforts to improve the quality of life for all of Delaware County's older adult population. If you have any questions please feel free to contact Delaware County Office for the Aging at 607-832-5750

A return self-addressed envelope has been included for your convenience.

Sincerely,

Wayne Shepard
Director Office for the Aging

Updated 7/10/18

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DELAWARE COUNTY RESIDENT COMMUNITY SURVEY

I live in the Village of ______________________________ **OR** Township of ______________________________

DEMOGRAPHICS: This information will be kept confidential and used only for statistical purposes

Gender: ❑ Male ❑ Female

Years of Age: ❑ Under 60 ❑ 60-64 ❑ 65-74 ❑ 75-84 ❑ 85-94 ❑ 95-99 ❑ 100+

Housing: ❑ Own ❑ Rent ❑ Senior/Subsidized Housing

Living Arrangements: ❑ Live Alone ❑ Spouse/Domestic Partner Only
❑ Spouse/Domestic Partner and Others ❑ Relatives ❑ Non-Relatives

How many people live in your household? (Please include yourself): __________

Marital Status: ❑ Married ❑ Widowed ❑ Divorced/Separated ❑ Never Married

Race: ❑ Amer. Ind/Alaskan Nat. ❑ Asian ❑ Black/African Amer. ❑ Hawaiian/Pacific Islander
❑ Hispanic ❑ White ❑ Other (list): ____

PLEASE CHECK WHICH HOUSEHOLD SIZE (Size) AND MONTHLY INCOME APPLY

Size	Monthly Income	Monthly Income	Monthly Income	Monthly Income	Monthly Income
1	❑ $ 973 or Less	❑ $ 974 - $1,216	❑ $1,217 - $1,459	❑ $1,459 - $1,799	❑ OVER $1,799
2	❑ $1,311 or Less	❑ $1,312 - $1,639	❑ $1,640 - $1,966	❑ $1,967 - $2,425	❑ OVER $2,425
3	❑ $1,649 or Less	❑ $1,650 - $2,062	❑ $2,063 - $2,474	❑ $2,475 - $3,051	❑ OVER $3,051

Please rate the following by checking one box in each of the following in regards to their importance to you!

HOUSING	**IMPORTANT** and **a** **CONCERN**	**IMPORTANT** but **NOT** a **CONCERN**	**NOT IMPORTANT** and **NOT** a **CONCERN**
Able to perform household chores (cleaning, etc.)	❑	❑	❑
Able to perform personal care (bathing, dressing, etc.)	❑	❑	❑
Accessibility in the home (ramps, accessible bathrooms, etc.)	❑	❑	❑
Finding reliable help to perform home maintenance/repairs	❑	❑	❑
Ability to financial afford home maintenance/repairs	❑	❑	❑
Ability to pay rent or taxes	❑	❑	❑
Able to pay for home heating	❑	❑	❑

What type of housing do you currently live in?
❑ Apartment ❑ One Level House ❑ Multi-Level House ❑ Senior/Supported Housing

If you had to move from your current living situation, would you consider any of the following?
❑ Apartment ❑ One Level House ❑ Multi-Level House ❑ Senior/Supported Housing

TRANSPORTATION	**IMPORTANT** and **a CONCERN**	**IMPORTANT** but **NOT** a **CONCERN**	**NOT IMPORTANT** and **NOT** a **CONCERN**
To local medical appointments	❑	❑	❑
To out of county medical appointments	❑	❑	❑
To the grocery store and other errands	❑	❑	❑
Driving my own car	❑	❑	❑
Using Delaware County Senior Bus (our local bus system)	❑	❑	❑
INSURANCE/HEALTH & WELLNESS			
Understanding Medicare and various options	❑	❑	❑
Understanding low-income health insurance subsidies	❑	❑	❑
Understanding long term care services and supports	❑	❑	❑
Accessing services for individuals with Alzheimer's or dementia and their caregivers	❑	❑	❑
Managing a chronic health condition(s)	❑	❑	❑
Wellness programs, including exercise classes	❑	❑	❑
Preventing falls, improving balance, dealing with fear of falling	❑	❑	❑
NUTRITION/FOOD			
Having enough money for nutritious food	❑	❑	❑
Being able to shop and cook for myself	❑	❑	❑
Able to follow a special diet recommended by my doctor	❑	❑	❑
SERVICES/SUPPORTS			
Respite services for caregivers of people with dementia or other functional impairments	❑	❑	❑
Transportation options for those unable to drive	❑	❑	❑
In-home personal care services	❑	❑	❑
Ability to participate in Congregate Dining Centers or receive Home Delivered Meals	❑	❑	❑
A centralized Senior Center for activities and meals	❑	❑	❑

CAREGIVERS – If you are caring for another individual, please answer the following questions:

For whom do you provide care?

❑ Spouse ❑ Parent ❑ Adult Child (21+) ❑ Child (20 and younger) ❑ Non-Relative

Does this individual live in your home? ❑ Yes ❑ No

Does this individual have memory problems and/or dementia? ❑ Yes ❑ No

Do you feel overwhelmed and/or stressed in providing care? ❑ Yes ❑ No

HELP AND SUPPORT – Where you turn for help:

If you, or someone you know, have been in the hospital in the past year, did you/they have the information and supports needed to return home? ❑ Yes ❑ No ❑ Not Applicable

Have you heard of "NY Connects," the local program that helps consumers with information, assistance and connections to needed long term care services and supports? ❑ Yes ❑ No

Do you feel you have enough contact with others, (seeing friends, social engagements, etc.)? ❑ Yes ❑ No

SERVICES AVAILABLE AT THE OFFICE FOR THE AGING	Have Used	Need	Don't Need
Home Delivered Meals *(Meals-on-Wheels)*	❑	❑	❑
Senior Dining Centers	❑	❑	❑
Nutrition Counseling (Information on special diet needs, etc.)	❑	❑	❑
Farmers Market Coupons	❑	❑	❑
Assistance in the home for yourself. - Housekeeping/Chores *and/or* Personal Care (Bathing, Dressing, etc.)	❑	❑	❑
Assistance in the home for someone you care *for:* - Housekeeping/Chores *and/or* Personal Care (Bathing, Dressing, etc.)	❑	❑	❑
Caregiver/Respite Services	❑	❑	❑
Support Groups (Caregivers or Alzheimer's)	❑	❑	❑
Personal Emergency Response System (Link to Life)	❑	❑	❑
Assistance with Understanding Health Insurance	❑	❑	❑
Legal Services (Wills, POA, Health Care Proxy) Other Legal Services Needed (please list):______________________________ ____	❑	❑	❑
Transportation Services (Rides to medical appointments, shopping, errands, meals, etc.)	❑	❑	❑
Assistance with Utility Bills	❑	❑	❑
Federal and State Tax Return Assistance	❑	❑	❑
Assistance with General Information	❑	❑	❑

COMMENTS (Needs or Services NOT covered above, list here or on the back):________________________________

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OPTIONAL (Please complete if you would like us to contact you about services or with more information):

Name: ____ Phone #: ________________________________

Address: ____

Email Address: ____

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