

# Orange County Senior Living Needs Survey

1. Current Home Zip Code \_\_\_\_\_ 2. What City do you live in? \_\_\_\_\_
3. See list of services below. How important are these types of services to YOU as you age?

| <i>Please check one box per service.</i>  | Extremely Important | Very Important | Somewhat Important | Not Very Important | Not At All Important |
|---|---------------------|----------------|--------------------|--------------------|----------------------|
| <b>In-Home Care</b>   |                     |                |                    |                    |                      |
| <b>Home-Delivered Meals (Meals on Wheels)</b>   |                     |                |                    |                    |                      |
| <b>Case Management</b><br>A person to help me access resources and services   |                     |                |                    |                    |                      |
| <b>Housing</b><br>Assistance with referrals to housing (i.e. apartments, residential care facilities)                           |                     |                |                    |                    |                      |
| <b>Legal Advice and Counseling</b>  |                     |                |                    |                    |                      |
| <b>Congregate Meals</b><br>Group meals provided in a senior/community center  |                     |                |                    |                    |                      |
| <b>Personal/Home Safety</b><br>For example, law enforcement, fall prevention and medical alert services, fraud protection, etc. |                     |                |                    |                    |                      |
| <b>Home Repairs/Modifications</b>   |                     |                |                    |                    |                      |
| <b>Family Caregiver Support Assistance</b><br>Support services for unpaid family caregivers                                     |                     |                |                    |                    |                      |
| <b>Adult Day Care Services</b><br>Daytime programs at a local center for social activities and some medical care                |                     |                |                    |                    |                      |
| <b>Socialization Services</b><br>Ongoing telephone calls and/or in-person visits from staff/volunteers                          |                     |                |                    |                    |                      |
| <b>Respite Care</b><br>Short-term care service for loved ones in order to give caregivers a break                               |                     |                |                    |                    |                      |
| <b>Mental Health Counseling</b>   |                     |                |                    |                    |                      |
| <b>Personal Affairs Assistance</b><br>Help with completing forms and electronic documents                                       |                     |                |                    |                    |                      |
| <b>Language Translation Services</b>  |                     |                |                    |                    |                      |
| <b>Financial Assistance</b><br>Help meeting your personal/financial needs (i.e. household/nutrition expenses, medical costs)    |                     |                |                    |                    |                      |
| <b>Peer Counseling Services</b><br>Connect with fellow seniors who are trained to provide assistance and support                |                     |                |                    |                    |                      |

Please turn over to next page

4. How often are your social activities and medical needs limited by lack of transportation?

- Never
- Rarely
- Sometimes
- Often

5. If you do not drive your own car, what other types of transportation do you use?

(Select all that apply)

- Family/Friend
- OCTA Bus
- OCTA ACCESS
- Taxi Cab
- Community Center/Senior Center Van
- Medical Transportation
- Ride Share App such as Uber/Lyft
- Other, please specify:  
\_\_\_\_\_
- None of the above, I am still driving

6. In regards to Financial Assistance, which of the following are you most concerned about?

(Please select one)

- Monthly household expenses (utilities, rent or mortgage, bills, home repairs, food)
- Monthly medical costs (insurance, prescriptions, co-pays)
- Not concerned

7. Does your physical health limit any of the following activities?(Select all that apply)

- Social Activities
- Doing House Work
- Personal Care
- Running Errands
- Going to Appointments
- None of the above

8. How often do you find yourself canceling plans or appointments because you are “too tired” or “not feeling well”?

- Never
- Rarely
- Sometimes
- Often

You're not done yet! Turn to the next page, please!

9. Of the following ways to connect with others, which one is most appealing to you?

(Please select one)

- Someone to regularly talk with in person or over the phone
- More companionship or contact with other people in your home/community
- Interaction with others via email and/or social media, such as Facebook

10. In regard to your Personal/Home Safety, which of the following are you most concerned about? (Please select one)

- Physical safety (i.e. falls, bodily injuries)
- Home Safety (i.e. burglaries, home disasters)
- Financial Safety (i.e. fraud, identity theft)
- Not Concerned

11. Do you have a disaster preparedness kit/plan that is easily accessible?

- Yes
- No
- Not Sure

12. If yes, how often do you check your disaster preparedness kit/plan to be sure that it includes enough food, water and medication to last at least 3 days?

- Never
- Rarely
- Sometimes
- Often

The following questions are required by the California Department of Aging. Your entries are strictly confidential. Your personal information will not be shared.

13. Age:

- 18-30
- 31-44
- 45-59
- 60-74
- 75-84
- 85+

14. Race (Select One)

- White
- Black/African American
- Pacific Islander
- Asian
- American Indian/Alaska Native
- Other: \_\_\_\_\_
- Declined to State

Almost there! One more page to go!

**15. Ethnicity (check one)**

Hispanic or Latino

Yes

No

Declined to State

**16. Educational Background**

Less than High School

High School Graduate

Bachelor's Degree or Higher

**17. Income Level (yearly)**

Less than \$15,000

\$15,000-\$34,999

\$35,000-\$74,999

\$75,000-\$99,999

\$100,000 or more

**18. What was your sex at birth?**

Male

Female

Decline to answer

**19. Gender**

Male

Female

Trans Male

Trans Female

Gender-Queer/Gender Non-binary

Not Listed. Please Specify:  
\_\_\_\_\_

**20. How do you describe your sexual orientation or sexual identity?**

Straight/Heterosexual

Bisexual

Gay/Lesbian/Same-Gender Loving

Questioning/Unsure

Not Listed. Please Specify:  
\_\_\_\_\_

Decline to answer

**OPTIONAL:**

To receive a follow-up call and referrals for any urgent needs, please provide your personal contact information below and a representative from the Orange County Office on Aging will contact you. Your personal information will not be shared.

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Topic(s) of Concern: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please Return to Cynthia Okialda at  
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Congratulations, you have finished! Thank you for your participation!