COMMUNITY ASSESSMENT

TOWN:_________________ DATE: __________

GENERAL:
What is your age? _____ Under 21 _____ 21-29 _____ 30-39 _____ 40-49 _____ 50-59
_____ 60-69 _____ 70-79 _____ 80-89 _____ Over 90
Are you caring for a loved one, or do you yourself need care on a day to day basis? __________
How many other family, friends and neighbors also need help? __________
Are you getting help to fill this out? __________
What do you or any of your loved one need help with? (check ALL that apply)
_____ transportation _____ chores _____ moving around the house _____ dressing
_____ medication schedules _____ making meals _____ eating _____ bathing _____ toileting
Who provides that service? _______________
Who provides in-home care in your town outside of your own family? _______________
Do you or any of your loved ones live alone and need extra help? _______________
Are you worried about you or any of your loved ones being alone without help?
________________

MEDICAL
Do you have medical insurance? __________ What kind? __________
How many miles is it to the nearest medical provider? _______________
How many miles is it to YOUR (or your loved one’s) preferred medical provider? __________
How many miles is it to the nearest hospital? __________
When is the last time that you or your loved one saw a dentist? __________
Are you on medications? __________ Are you able to fill them as prescribed? __________
Do you or your loved one have other special medical needs? _______________
Can you or your loved one walk unaided? __________
Can you or your loved one move around without being out of breath or off balance? __________
Do you or your loved one have any assistive devices (cane walker, prosthetics, wheelchair, oxygen)?
____________
How does you or your loved one get supplies? _______________
Do you or your loved one go without medical supplies so that you can have enough to eat?
____________
TRANSPORTATION
Do you or your loved one own a vehicle? __________
How many times a day OR week does public transportation run through town? __________
Do you have family, friends or neighbors that help you get to scheduled appointments? __________ How many different people? __________
How many of your closest family and friends who can help you own a car? __________

NUTRITION
Are your or any of your loved ones receiving food stamps? __________
How many of them are over the age of 55? __________
How long does you or your loved ones food stamps last in any given month (in weeks)? __________
How many meals do you or your loved one eat a day? __________
How many times a month do you need the extra food provided by a food bank? __________
How many miles is it to the nearest food bank? __________
Do you or any of your loved ones have a special diet for a medical condition? __________
Are you able to follow that diet? __________
How many miles is it to the nearest grocery store? __________
Does this grocery store carry fresh vegetables, eggs, fish & meat? __________
How many varieties of vegetables, fish & meat are available at your nearest grocery store? __________
How close is the nearest grocery store that carries ALL the food that you feel you need for a week? __________
How many times a week do you or your loved one eat fresh food (not from a can or pre-packaged)? __________
How many times a week do you or your loved ones eat eggs, fish or meat? __________

COMMUNICATION
Do you own a computer? __________ Do you use computers? __________
Do you have an email account? __________ Do you know how to use email? __________
Do you have a home phone? __________
Do you have a answering machine or service? __________
Do you have a cell phone? __________
Do you have a month to month service plan or pay for minutes (with a card)? __________
SOCIAL

How many times a week do you or your loved one engage in activities? __________

Do you have a senior center in your community? __________

Does it have regular hours? __________

Check each of the things that you or your loved one does each week? How many times do you or your loved one do this activity/week? And how many total hours per week you spend doing that activity?

_____ Senior Center _____ times _____ hours

_____ Church _____ times _____ hours

_____ Library _____ times _____ hours

_____ Movies _____ times _____ hours

_____ Shopping _____ times _____ hours

_____ Physical fitness _____ times _____ hours

_____ Time alone _____ times _____ hours

KNOWLEDGE

Do you know how to help someone move from seating to standing position safely? __________

Do you know the best way to help people with mobility problems walk with assistance? __________

Do you know when it is necessary to call for medical assistance? __________

Do you know CPR? __________

Do you know how to support independent decision making in aging and disabled family and friends? __________

Do you know how to advocate for appropriate care options and choice? __________

Do you know important nutritional requirements for chronic disease states common in aging? __________

WOULD YOU LIKE TRAININGS TO HELP YOU OR YOUR CAREGIVERS UNDERSTAND SOME OF THE DAILY NEEDS OF THE ELDERS IN YOUR COMMUNITY? __________

WOULD YOU LIKE TO DISCUSS THE IMPACT OF LONELINESS AND ISOLATION ON YOU AND YOUR LOVED ONE? __________

WHAT OTHER INFORMATION CAN HELP YOU OR YOUR LOVED ONE STAY HEALTHY WITHIN YOUR OWN HOME AND COMMUNITY?

________________________________________________________________________

THANK YOU FOR YOUR TIME!
This is the page that lets you share those community issues that are of most concern for you and your loved ones. Please number each of them. (If you need additional room, you can add additional pieces of paper).