18th ACL National Survey of Older Americans Act Participants
Caregiver Questionnaire

This is the U.S. Department of Health and Human Services' Administration for Community Living (ACL) National Survey of Older Americans Act Participants (NSOAAP) for people receiving services from the National Family Caregiver Support Program (NFCSP).

It is very important that the questions in this booklet be answered by the person addressed in the letter. That person may receive assistance filling out the questionnaire, if needed, but the questions should be answered from his or her point of view.

You may skip any question that you do not want to answer, but we would really appreciate your answering all the questions you can.

MAILING INSTRUCTIONS: Please return your completed questionnaire in the pre-addressed postage paid envelope. If you have any questions about the questionnaire, please feel free to call us at 1-855-519-7052.

A. Caregiver Support Services

A1. Are you taking care of another adult person aged 60 years or older?

a. Yes
b. Unsure
c. No

If you marked No:
THANK YOU. The focus of this survey is on informal caregivers who are currently providing care to a family member or loved one. If you are not currently a caregiver for another adult person aged 60 years or older, please stop here and go to mailing information on page 21. Thank you for your interest in participating.

In this survey, we refer to the person who is being cared for as the "Care Receiver" and the person providing care as the "Caregiver".

A2. Do you help your care receiver with…?

	Yes	No
a. Activities like dressing, eating, bathing, or getting to the bathroom	☐	☐
b. Medical needs such as taking medicine or changing bandages	☐	☐
c. Keeping track of bills, checks, or other financial matters	☐	☐
d. Preparing meals, doing laundry, or cleaning the house	☐	☐
e. Local trips, such as going shopping or to the doctor's office	☐	☐
f. Arranging for care or services provided by others	☐	☐

A3. Did you mark "Yes" to any of the activities above (items a-f)?

a. Yes (go to A4)
b. No

If you marked No:
THANK YOU. The focus of this survey is on informal caregivers who are currently providing care to a family member or loved one. If you are not currently a caregiver for another adult person aged 60 years or older, please stop here and go to mailing information on page 21. Thank you for your interest in participating.

A4. What prompted you to contact the Area Agency for Aging?

a. Medical or health issue or hospitalization
b. Spouse, son/daughter, sibling, friend no longer able to help
c. Paid caregiver quit
d. Recently moved to the area
e. Needed transportation
f. Just wanted information
g. Waiting list
h. Needed assistance locating or accessing services
i. Don't remember

A5. How long have you been receiving caregiver support services?

a. 6 months or less
b. More than 6 months, but less than 1 year
c. At least 1 year, but less than 2 years
d. 2 to 5 years
e. 5 to 10 years
f. 11 to 20 years
g. More than 20 years
h. Never received caregiver support services

If you marked "Never received caregiver support services":
THANK YOU. The focus of this survey is on informal caregivers who are currently providing care to a family member or loved one and receiving services from the National Family Caregiver Support Program provided through an Area Agency on Aging. If you have not received any caregiver support from this program, please stop here and go to mailing information on page 21. Thank you for your interest in participating.

A6. We're interested in understanding your relationship with the person you take care of (your care receiver). For example, if the care receiver is your husband, mark "Wife".

You are your care receiver's...

a. Husband
b. Wife
c. Partner
d. Son or Step-son
e. Son-in-law
f. Daughter or Step-daughter
g. Daughter-in-law
h. Father
i. Mother
j. Mother-in-law or father-in-law
k. Brother
l. Sister
m. Sister-in-law or brother-in-law
n. Granddaughter
o. Grandson
p. Niece
q. Nephew
r. Cousin
s. Other relative
t. A friend or a neighbor or another person

The next few questions are about caregiving experiences.

A7. If your care receiver needed a greater amount of care, would you be able to increase your caregiving responsibilities?

a. Yes
b. No

A8. Do you know where to go to ask for respite care? *Respite care allows you a brief period of rest or relief while temporary care is provided to your care receiver in your home or your care receiver's home or someplace else.*

a. Yes
b. No

A9. Have you attended caregiver education or training such as classroom or on-line courses?

a. Yes (go to A11)
b. No

A10. Do you have a need for caregiver education or training, such as classroom or on-line courses?

a. Yes
b. No

A11. Have you attended counseling to assist with your specific caregiving situation?

a. Yes (go to A13)
b. No

A12. Do you have a need for counseling to assist with your specific caregiving situation?

a. Yes
b. No

A13. Have you attended caregiver support groups?

a. Yes (go to A15)
b. No

A14. Do you have a need for attending caregiver support groups?

a. Yes
b. No

A15. In the last year, have you needed assistance with applying or accessing other programs or services for your care receiver or yourself?

a. Yes
b. No

A16. Have the family caregiver services provided supplemental services such as…?

	Yes	No
a. Home modifications, such as a ramp or grab bar	☐	☐
b. Liquid nutritional supplements, such as Ensure, Boost, or Glucerna	☐	☐
c. Walkers, canes, crutches, Hoyer Lift, microwaves	☐	☐
d. Emergency response systems, CPAP or apnea machines, hospital bed, a device to monitor wandering	☐	☐
e. Consumable supplies such as wound care, catheter, or incontinence supplies *(Consumable supplies are things that you use once and throw away.)*	☐	☐
f. Money or stipend	☐	☐

A17. As a result of the caregiver services you have received, do you…?

	Yes	No
a. Have more time for personal activities	☐	☐
b. Feel less stress	☐	☐
c. Find it easier to care for your care receiver	☐	☐
d. Have a clearer understanding of how to get the services you and your care receiver need	☐	☐
e. Know more about your care receiver's condition or illness	☐	☐

A18. Have these caregiver services helped you to be a better caregiver?
a. Yes
b. No

A19. Have these caregiver services enabled you to provide care for your care receiver for a longer time than would have been possible without these services?
a. Yes
b. No

A20. Overall, how would you rate the caregiver support services you received?
a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

A21. Has it been difficult for you to get services from agencies for your care receiver?
a. Yes
b. No

B. Caregiving and Employment/Expenses

The next few questions are about your employment.

B1. Are you currently employed?
a. Yes
b. No (go to B5)

B2. Has providing care for your care receiver interfered with your job?
a. Yes
b. No (go to B5)

B3. Because of providing care for your care receiver, did you…?

	Yes	No
a. Take a less demanding job	☐	☐
b. Change from full-time to part-time work or reduce your official working hours	☐	☐
c. Lose some of your employment fringe benefits	☐	☐
d. Have time conflicts between working and caregiving	☐	☐
e. Use your vacation time to provide care	☐	☐
f. Take a leave of absence to provide care	☐	☐
g. Lose a promotion	☐	☐
h. Work less than your normal number of hours last month	☐	☐

B4. Did the caregiver support services help you deal with these work difficulties?
a. Yes
b. No

B5. Due to caregiving-related changes in your employment or expenses, have you had to…?

	Yes	No
a. Dip into your savings	☐	☐
b. Cut back on your own spending for vacations or travel, entertainment, going out, or other leisure activities	☐	☐
c. Cut down on your own spending for groceries or meals	☐	☐
d. Cut back on your own spending on health care, dental care, or prescription medicine	☐	☐
e. Cut back on your own spending for household expenses and maintenance	☐	☐
f. Quit your job	☐	☐

The following questions are about your situation as a caregiver.

B6. How much satisfaction do you gain from performing your care tasks?
a. No satisfaction
b. Some satisfaction
c. A lot of satisfaction

B7. In the last year, have you used your own money to pay for your care receiver's…?

	Yes	No
a. Medications or medical care	☐	☐
b. Insurance premiums or copayments	☐	☐
c. Mobility devices, such as walkers, canes, or wheelchairs	☐	☐
d. Features that have made your care receiver's home safer, such as a railing or ramp, grab bars in the bathroom, a seat for the shower or tub or an emergency response system	☐	☐
e. Any other assistive devices that make it easier or safer to do activities or allow your care receiver to do them on their own	☐	☐

C. Well-Being and Health

C1. The following questions are about how **you** feel these days.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. How much of the time during the past four weeks have you felt calm and peaceful?	☐	☐	☐	☐	☐
b. How much of the time during the past four weeks have you had a lot of energy?	☐	☐	☐	☐	☐
c. How much of the time during the past four weeks have you felt downhearted or depressed?	☐	☐	☐	☐	☐

C2. Regarding your present social activities, do you feel that you are doing…

a. About enough
b. Too much
c. Would like to be doing more

C3. Have your social opportunities increased since you became involved with your Area Agency on Aging services?

a. Yes
b. No

C4. How often does…..?

	Always	Usually	Sometimes	Rarely	Never
a. Caregiving prevent you from having enough time for yourself	☐	☐	☐	☐	☐
b. Caregiving prevent you from having enough time for your family	☐	☐	☐	☐	☐
c. Caregiving conflict with your social life	☐	☐	☐	☐	☐
d. Being a caregiver for your care receiver give you the joy of spending time with someone you care about	☐	☐	☐	☐	☐
e. Being a caregiver provide you with a sense of accomplishment	☐	☐	☐	☐	☐

C5. How often do you feel that your care receiver appreciates the care that you are providing?

a. Always
b. Usually
c. Sometimes
d. Rarely
e. Never

C6. As a caregiver, how often do you feel you are fulfilling your duty by caring for your care receiver?

a. Always
b. Usually
c. Sometimes
d. Rarely
e. Never

C7. For the next set of questions, please respond to how true the statement is for you.

	Not at all true	Hardly true	Moderately true	Exactly true
a. You are confident that you could deal efficiently with unexpected events.	☐	☐	☐	☐
b. You can remain calm when facing difficulties because you can rely on your coping abilities.	☐	☐	☐	☐
c. You can usually handle whatever comes your way.	☐	☐	☐	☐

C8. Compared to one year ago, how would you rate your health in general now? Would you say…

a. Much better
b. Somewhat better
c. About the same
d. Somewhat worse
e. Much worse

C9. In the past month, have you been bothered by pain?

a. Yes
b. No (go to C11)

C10. In the last month, how often has pain limited your activities?

a. Every day
b. Most days
c. Some days
d. Rarely
e. Never

C11. In the past 12 months, have you been to see a doctor or gone to an urgent care center? *Do not include going to the hospital emergency department. Doctor includes Physician Assistant or Nurse Practitioner.*

a. Yes
b. No

C12. In the past 12 months, have you ever missed or delayed routine doctor visits because of your caregiving situation?

a. Yes
b. No

C13. In the past 12 months, did you go to a hospital emergency department for a health problem of your own?

a. Yes
b. No (go to C15)

C14. In the past 12 months, how many times did you go to a hospital emergency department?

_____ Number of times at hospital emergency department

C15. In the past 12 months, did you have to stay overnight in a hospital?

a. Yes
b. No (go to D1)

C16. In the past 12 months, how many times were you hospitalized for one night or longer?

_____ Number of times hospitalized overnight

D. Caregiving Situation

D1. Thinking about all the family members or friends who provide help, care, or supervision for your care receiver, what proportion of the care do **you** provide during a typical week?

a. Less than one-quarter
b. About one-quarter
c. About one-half
d. About three-quarters
e. All or almost all of the care

The next set of questions ask about any thoughts you have had about alternative types of care.

D2. In the past 6 months, have you ever considered a nursing home, boarding home, or assisted living for your care receiver?

a. Yes
b. No

D3. In the past 6 months, have you felt that your care receiver would be better off in a nursing home, boarding home, or assisted living facility?

a. Yes
b. No (go to D6)

D4. In the past 6 months, have you discussed that possibility with your care receiver?

a. Yes
b. No (go to D6)

D5. In the past 6 months, have you taken any steps toward placement?

a. Yes
b. No

D6. Are you responsible for providing help or supervision to your care receiver on a 24-hour basis?

a. Yes
b. No (go to D8)

D7. On a scale from 1 to 5 where 1 is not very intense and 5 is very intense, how intense is the care you provide? _____

D8. Would you recommend the caregiving support services to a friend?
a. Yes
b. No

D9. Do you have any recommendations to improve the caregiver support services?
a. Yes
b. No (go to D11)

D10. Choose **one** type of caregiver support service you have received that you think needs the most improvement?
a. Information about available services
b. Assistance gaining access to services
c. Caregiver education/training, individual counseling, and support groups
d. Respite care
e. Other supplemental services
f. Something else

D11. Overall, do you feel like you have enough support?
a. Yes
b. No

E. Nutrition

E1. In the past 12 months, have you tried to get meals, food, or groceries through your Area Agency on Aging (AAA)?
a. Yes
b. No (go to E2)

E1a. Were you unable to get food?
a. Yes
b. No (go to E2)

E1b. Were you unable to get meals, food, or groceries from your Area Agency on Aging for any of the following reasons? *Mark all that apply.*
a. No response from AAA
b. I was put on a waiting list
c. I was told that I could not have more meals or food
d. I was told there was no more food available
e. I was told there was not enough staff
f. I was unable to pick up the meals or get to the meal pick-up place

E2. Have you recently lost weight without trying? If you are unsure, some things that might indicate weight loss are clothes or rings fitting looser, or using a different belt notch.

a. Yes
b. No (go to E3)

E2a. How much weight have you lost?

a. 2-13 lbs
b. 14-23 lbs
c. 24-33 lbs
d. 34 lbs or more
e. Unsure

E3. Have you been eating poorly because of a decreased appetite? For example, eating less than 75% of your usual intake. Most often this is due to poor appetite, but there may be other reasons sometimes such as chewing or swallowing difficulties.

a. Yes
b. No

E4. Have you recently gained weight without trying?

a. Yes (go to E4a)
b. No
c. Unsure

E4a. How much weight have you gained?

_____ Number of pounds

Below are several statements that people have made about their food situation. They use the terms "we" and "your household". A household includes everyone who lives with you. If you live alone, then you are a household of one.

E5. "The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months?

a. Often true
b. Sometimes true
c. Never true

E6. "We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for your household in the last 12 months?

a. Often true
b. Sometimes true
c. Never true

E7. In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

a. Yes
b. No (go to E8)

E7a. How often did this happen?

a. Almost every month
b. Some months but not every month
c. Only 1 or 2 months

E8. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

a. Yes
b. No

E9. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

a. Yes
b. No

F. Care Receiver Additional Services

F1. These next questions ask about additional help your care receiver (CR) may have received from your Area Agency on Aging (AAA).

	Yes	No
a. In the past year, has your CR attended a meals program at a senior center or other group setting?	☐	☐
b. In the past year, has your CR received meals or other food from the meals program?	☐	☐
c. In the past year, has your CR received Homemaker or Housekeeping services? (*These are services that may include help with doing light housework, laundry, preparing meals, shopping, or delivery of groceries or prescriptions*.)	☐	☐
d. In the past year, has your CR received case management services? (*When someone receives case management, they have a case manager who may set up in-home services, such as homemaker or personal care services for them. The case manager may also call to check on how they are doing, or how they like the services.)*	☐	☐
e. In the past year, has your CR received transportation services?	☐	☐
f. In the past year, has your CR received adult daycare services? (*Adult Day Care or adult health is when people go to a place to spend the day.)*	☐	☐
g. In the past year, has your CR received personal care services? (*Personal care services are help with care like dressing or bathing.)*	☐	☐
h. In the past year, has your CR received heavy chore services, such as washing windows, yardwork, or shoveling snow? (*Chore Services help with heavier housecleaning and yard work.)*	☐	☐
i. In the past year, has your CR received legal assistance? (*Legal Assistance may help with making a will or understanding a bill and other legal matter.)*	☐	☐
j. In the past year, has your CR received information and assistance services? (*Information and Assistance helps people find out about services that are available to them.)*	☐	☐
k. Has your CR received flu shots, pneumonia shots, COVID vaccinations, or other immunizations from your AAA?	☐	☐

F2. Did you mark "Yes" to any of the additional services in the table above (items a-l)?

a. Yes
b. No (go to F4)

F3. Overall, how would you rate the **group** of services the person you care for receives?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

F4. Is the person you care for receiving any other types of assistance, such as…

	Yes	No
a. Food stamps	☐	☐
b. Energy Assistance	☐	☐
c. Medicaid	☐	☐
d. Housing Assistance	☐	☐

F5. Does your care receiver's family or friends help arrange for the services your care receiver receives?

a. Yes
b. No

G. Preference and Needs Related to Community Living

Most older adults want to remain living in their homes and communities as they age. These next questions are about your care receiver's desire to remain living in their home and the types of home modifications and community supports that can help make this possible.

G1. How important is it for your care receiver to be able to stay in their current home for as long as possible?

a. Very important
b. Somewhat important
c. Not important

G2. Is the following statement often, sometimes, or never true?

"My care receiver worries about being able to afford living where they currently live for another year."

a. Often true
b. Sometimes true
c. Never true

G3. Is there a place or organization in your care receiver's community that feels welcoming for people their age to socialize, exercise, and/or participate in activities?

a. Yes (Go to G3a.)
b. No (Go to G4)
c. Don't know (Go to G4)

G3a. If Yes, does your care receiver go there?

a. Yes
b. No

G4. Does your care receiver have any of the following in their home?

	Yes	No	If No, would this be helpful for your care receiver?
a. Grab bars in the bathroom	☐	☐	☐ Yes ☐ No ☐ Don't know
b. Shower bench/chair	☐	☐	☐ Yes ☐ No ☐ Don't know
c. Ramp into home/no stairs for entry	☐	☐	☐ Yes ☐ No ☐ Don't know
d. Door frames wide enough for a wheelchair (i.e., 36 inches)	☐	☐	☐ Yes ☐ No ☐ Don't know
e. Roll in shower (i.e., no step or barrier when using a wheelchair or walker)	☐	☐	☐ Yes ☐ No ☐ Don't know
f. Raised toilet seat height (i.e., chair height)	☐	☐	☐ Yes ☐ No ☐ Don't know
g. Lever door handles (i.e., can be opened with a simple pull-down motion)	☐	☐	☐ Yes ☐ No ☐ Don't know
h. Main floor bathroom	☐	☐	☐ Yes ☐ No ☐ Don't know
i. Main floor bedroom	☐	☐	☐ Yes ☐ No ☐ Don't know
j. Stair lift	☐	☐	☐ Yes ☐ No ☐ Don't know

G5. How much consideration has your care receiver given to what modifications may be necessary for their home for them to be able to stay there as they age?

a. A lot
b. Some
c. Little
d. None

H. Falls

The next few questions are about falling down (any fall, slip, or trip in which you lose your balance and land on the floor or ground or at a lower level.)

H1. In the last month, have you fallen down?
- a. Yes
- b. No

H2. In the last month, did you worry about falling down?
- a. Yes
- b. No (go to section I)

H3. In the last month, did this worry ever limit your activities?
- a. Yes
- b. No

I. Social Integration

The next few questions are about your contact with other people.

I1. How often do you feel that you lack companionship?
- a. Hardly ever
- b. Some of the time
- c. Often

I2. How often do you feel left out?
- a. Hardly ever
- b. Some of the time
- c. Often

I3. How often do you feel isolated from others?
- a. Hardly ever
- b. Some of the time
- c. Often

I4. How often do you feel alone?
- a. Never
- b. Hardly ever
- c. Some of the time
- d. Often

J. Care Receiver Health Status and Medical Conditions

J1. In your judgment, if the services that you and your care receiver have received had not been available, would your care receiver be able to continue to live in the same residence?
- a. Yes (go to J3)
- b. No

J2. Where would your care receiver be living? *Mark only one.*

a. In caregiver's home
b. In the home of another family member or friend
c. In an assisted living facility
d. In a nursing home
e. Care receiver would have died
f. Other

The next few questions are about the health of your care receiver.

J3. In general, how is your care receiver's health?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

J4. Has a doctor ever said that your care receiver has….?

	Yes	No
a. Arthritis or rheumatism	☐	☐
b. High blood pressure or hypertension	☐	☐
c. A heart attack, coronary heart disease, angina, congestive heart failure, or other heart conditions	☐	☐
d. High cholesterol	☐	☐
e. Diabetes or high blood sugar	☐	☐
f. Allergies/asthma/emphysema/chronic bronchitis/other breathing or lung conditions	☐	☐
g. Cancer or a malignant tumor, excluding minor skin cancer	☐	☐
h. Stroke	☐	☐
i. Anemia (*such as iron-deficiency*)	☐	☐
j. Osteoporosis	☐	☐
k. Kidney disease	☐	☐
l. Eye or vision conditions such as glaucoma, cataracts, macular degeneration or other medical conditions (*This does not include needing to wear glasses or contact lenses.*)	☐	☐
m. Hearing loss or other hearing conditions	☐	☐
n. An emotional or mental health condition	☐	☐
o. Memory related disease such as Alzheimer's or dementia	☐	☐
p. Seizures or epilepsy	☐	☐
q. Parkinson's disease	☐	☐
r. Multiple Sclerosis	☐	☐
s. Serious bladder or bowel incontinence	☐	☐
t. Thyroid disease	☐	☐
u. A digestive or colon-related condition	☐	☐

J5. Does your care receiver have access to public transportation such as a bus or rail?
a. Yes
b. No

Now we would like to ask about oral or dental health, that is, the health of your care receiver's teeth and gums.

J6. About how long has it been since your care receiver last visited a dentist? Include dental hygienists, orthodontists, oral surgeons, and other dental-related specialists.
a. 6 months or less
b. More than 6 months, but not more than 1 year ago
c. More than 1 year, but not more than 2 years ago
d. More than 2 years, but not more than 3 years ago
e. More than 3 years, but not more than 5 years ago
f. More than 5 years ago
g. Never has been to a dentist
h. I don't remember

J7. During the past 12 months, was there a time when your care receiver needed dental care but could not get it at that time?
a. Yes
b. No

J8. Overall, how would you rate the health of your care receiver's teeth and gums?
a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

K. Care Receiver's Activities and Instrumental Activities of Daily Living (ADL/IADLs)

The next set of questions ask about your care receiver's ability to perform some common activities of everyday life and whether your care receiver needs assistance performing these activities. We are only interested in long-term conditions, not temporary conditions.

K1. Does your care receiver have difficulty…..?

	Yes	No
a. getting in or out of bed or a chair	☐	☐
b. when taking a bath or shower	☐	☐
c. when dressing	☐	☐
d. when walking or getting around inside the home	☐	☐
e. eating	☐	☐
f. using the toilet	☐	☐
g. going outside the home, for example to shop or visit a doctor's office	☐	☐
h. keeping track of money or bills	☐	☐
i. preparing meals	☐	☐
j. doing light housework, such as washing dishes or sweeping a floor	☐	☐
k. doing heavy housework, such as scrubbing floors or washing windows	☐	☐
l. taking the right amount of prescribed medicine at the right time	☐	☐
m. using the phone	☐	☐

K2. Is there a car or personal motor vehicle in working condition in your care receiver's household?

a. Yes
b. No

K3. Does your care receiver have difficulty driving a car or other personal motor vehicle?

a. Yes
b. No
c. Not applicable (because CR does not want or need to drive)
d. Not applicable (because household does not have a working vehicle)

K4. Does your care receiver have difficulty using public transportation such as a bus or rail?

a. Yes
b. No
c. Never uses public transportation

K5. What is your care receiver's current age?

_____ Age

L. Caregiving for Others

L1. How many persons total are you caring for not counting this care receiver? [If none, enter 0].

_____ Number of people

If you answered 0, go to section M.

L2. Not counting your care receiver, how are the other people you care for related to you? *Mark all that apply.*

a. Husband, wife, or partner
b. Son(s) or daughter(s)
c. Father
d. Mother
e. Brother(s) or sister(s)
f. Grandson(s) or granddaughter(s)
g. Cousin or other relative(s)
h. Friend(s) or neighbor(s)
i. Brother-in-law or sister-in-law
j. Other persons not mentioned above

M. Demographics

The purpose of the following questions is to help ACL and its network of AAAs better understand the level of satisfaction and needs of all clients based on several types of demographic information. The goal is to provide equitable community-based programs and support services to all clients. Only ACL's contracted research team will have access to this information. Your responses will be kept confidential and secure. Any reports and studies resulting from this survey will summarize information and not identify any individuals. The information will not be used for any discriminatory purpose.

M1. What is your age? _____

M2. What is your highest level of education?

a. Less than high school diploma
b. High school diploma or GED
c. Some college, including Associate's degree (includes business school and vocational or technical school)
d. Bachelor's degree
e. Some post-graduate work or advanced degree

M3. Are you Hispanic or Latino?

a. Yes
b. No

M4. Which one or more of the following best describes your race? *Mark all that apply.*

a. White
b. Black or African American
c. Asian
d. American Indian or Alaska Native
e. Native Hawaiian or other Pacific
f. Islander
g. Some other race (specify) _____

M5. Have you ever served on active duty in the U.S. Armed Forces, military Reserves or National Guard? Active duty does not include training for the Reserves or National Guard.

a. Yes
b. No

M6. Is your home located in…

a. The city
b. The suburbs
c. A rural area
d. Don't know

M7. What is your current marital status?

a. Married
b. Living with a partner
c. Widowed
d. Divorced
e. Separated
f. Never Married

M8. We'd like to ask about the persons who live in your household. Does anyone else live with you?

a. Yes
b. No (go to M9)

M8a. If yes...

(Only complete the table below if someone else lives with you.)

	Yes	No
1. Do you live with your spouse or unmarried partner?	☐	☐
2. Do you live in the home of one of your children?	☐	☐
3. Do one or more of your children live in your home	☐	☐
4. Do you live with other relatives?	☐	☐
5. Do you live with non-relatives?	☐	☐

M8b. Including yourself, how many people live in your household?

_____ Number of household members

M9. What is your sex?

a. Female
b. Male

M10. Thinking about the total combined income from all sources for all persons in your household, including income from jobs, Social Security, retirement income, public assistance, and all other sources, which category best describes your total household annual income during the year 2023?

a. $5,000 or less ($417 or less per month)
b. $5,001 - $10,000 ($418 to $833 per month)
c. $10,001 - $15,000 ($834 to $1,250 per month)
d. $15,001 - $20,000 ($1,251 to $1,666 per month)
e. $20,001 - $25,000 ($1,667 to $2,083 per month)
f. $25,001 - $30,000 ($2,084 to $2,500 per month)
g. $30,001 - $35,000 ($2,501 to $2,917 per month)
h. $35,001 - $40,000 ($2,918 to $3,333 per month)
i. $40,001 - $50,000 ($3,334 to $4,167 per month)
j. Over $50,000 ($4,168 or more per month)
k. Prefer not to answer

M11. Did someone else complete this survey for the person addressed in the letter?

a. Yes
b. No

THANK YOU!

Your answers will help us better evaluate the services funded by the Older Americans Act.

Please return your completed questionnaire in the pre-addressed postage paid envelope to:

Westat
1600 Research Blvd., Room # RCB16
Rockville, MD 20850