Caregiver Pre-Survey Welcome to the Community Care Corps Survey!



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The following section is MANDATORY.

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For example, my name is **Ma**ria **Jo**nes and I was born in 19**71**. My ID is **MAJO71**.

Please write your answers here:

First two letters of your FIRST name:

First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

- O A Little Help
- O CaringMatters
- O Duet: Partners in Health and Aging
- O FamilyMeans
- O Hospice of the Valley
- O Institute for Community Equity and Sharing, Inc. dba One Community
- Jewish Family and Children's Service of Greater Philadelphia
- O Lifespan of Greater Rochester
- O Lutheran Senior Services
- O MAB Community Services
- O NeighborLink Indianapolis Foundation Inc
- O On My Own of Michigan

- O Peninsula Agency on Aging
- O Penn Memory Center, University of Pennsylvania
- O Prisma Health–Upstate
- O REACH Community Respite Ministry
- O Rebuilding Together New Orleans
- O SeniorAge
- O SAGE
- O Sibling Leadership Network
- O United Home Care Services Inc. d/b/a United HomeCare
- O West Virginia School of Osteopathic Medicine
- Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

We know that caregiving can be hard and stressful. We hope that participation in this program will help relieve some of the burden you may be feeling. Please know that your responses to the following questions are private and intended only to let us know if the volunteer assistance you receive has been helpful.

QUALITY OF LIFE

Ηοι	How would you rate your quality of life? Please choose only one of the following:								
0	Very good	0 0	Good	0	Fair	0	Poor	0	Very poor
Dui	ring the past month,	, how	often have you fel	lt do	wnhearted and blu	e ? P	lease choose only d	one o	f the following:
0	All of the time	0	Nost of the time	0	Some of the time	0	Never	C	2
Dui	ring the past month,	, how	often have you fe	lt wo	orried? Please choos	se or	nly one of the follow	wing:	•
0	All of the time	0 1	Nost of the time	0	Some of the time	0	Never		
Dui	ring the past month,	, how	often have you fe	t loi	nely? Please choose	only	one of the followi	ing:	
0	All of the time	0	Most of the time	0	Some of the time	0	Never		
Ove	erall, how would you	u des	cribe your physical	hea	Ilth? Please choose	only	one of the followir	ng:	
0	Excellent	0 0	Good	0	Fair	0	Poor		
Ov	erall, how would yo	u des	cribe your mental	hea	Ith? Please choose o	only	one of the followin	g:	
0	Excellent	0 0	Good	0	Fair	0	Poor		
EX	PERIENCE								
Но	(PERIENCE w difficult is it for yo y one of the followir		maintain the curre	nt li	ving situation of the	e per	son you provide ca	are fo	r? Please choose
Ho v onl	w difficult is it for yc	ng:			-	-	son you provide c a Extremely difficult		or? Please choose
Hov onl	w difficult is it for yc y one of the followir	ng: O S	Somewhat difficult	0	Difficult	0	Extremely difficult		or? Please choose
Hov onl O	w difficult is it for yc y one of the followir Not at all difficult	ng: O S capat	Somewhat difficult	O Plea	Difficult	O of th	Extremely difficult		or? Please choose
Hov onl O Hov	w difficult is it for yo y one of the followin Not at all difficult w often do you feel	ng: O S capat	Somewhat difficult ble as a caregiver? Most of the time	O Plea O	Difficult se choose only one Some of the time	O of th O	Extremely difficult te following: Never		o r? Please choose

Abo	out how often do you	ı pro	ovide care for this pe	erso	n? Please choose on	ly or	ne of the following:		
0	Daily	0	A couple of times per week	0	Weekly	0	A couple of times per month		
Ove	erall, how often do yo	ou f	eel stressed by prov	idin	g care? Please choos	e or	ly one of the follow	ing:	
0	Never	0	Rarely	0	Sometimes	0	Quite frequently	0	Nearly always
	you having feelings owing:	of b	eing overwhelmed,	ove	r-worked, and/or ov	verb	u rdened? Please ch	oose	only one of the
0	All of the time	0	Most of the time	0	Some of the time	0	Never		5
D	MOGRAPHICS						0		
Wh	at age did you turn o	n ye	our last birthday?				\mathcal{C}		
Wh	at is your employme	nt s	tatus? Please choose	e all	that apply:				
□ □ □ ₩h	Full-time student Part-time student Employed full-time Employed part-time ich of these best des	crib	e your race and/or e	ethn	Retired Semi-ret icity? Please choose	tired	•		
	American Indian or A Asian Black or African Ame Hispanic, Latino, or S	rica	n		WhitePrefer n	ot to	iian or Other Pacific		nder
Wh	at is your educationa	l le	vel? Please choose o	nly	one of the following				
0 0 0	Less than High Schoo High School Diploma Some College/Trade College/Trade Schoo Post-Graduate Degre	or l Sch I Gr	ool						
Wh	at gender do you ide	ntif	y as? Please choose	only	one of the following	g:			
Ο	Male Female Non-binary Prefer not to say								
Ο	Other:								

How are you connected to the person for whom you provide care? (Note - the choices in this list include step, foste	٢,
and in-laws) I am their Please choose only one of the following:	

Ο	S	pc	วน	s	e

- O Parent
- O Child
- O Sibling
- O Grandparent
- O Grandchild

- O Aunt/Uncle
- O Niece/Nephew
- O Cousin
- O Other Relative
- O Friend
- O Neighbor

Where does the person for whom you provide care currently live? Please choose only one of the following:

- O In their own home (e.g., house, apartment, trailer, etc.)
- O Senior Housing
- O Assisted Living Facility
- O Life Plan Community or Continuing Care Retirement Community
- O In my home or in another family member's home
- O With a friend or roommate
- O In a group home
- O Other: _____

Do you identify as a person with a disability? Please choose only one of the following:

O Yes

O No

O Prefer not to say

Do you have a long-term health condition? Please choose only one of the following:

- O Yes
- O No

Prefer not to say

Thank you for completing this survey.

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For example, my name is **Ma**ria **Jo**nes and I was born in 19**71**. My ID is **MAJO71**.

Please write your answers here:

First two letters of your FIRST name:

First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

- O A Little Help
- O CaringMatters
- O Duet: Partners in Health and Aging
- O FamilyMeans
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- O Institute for Community Equity and Sharing, Inc. dba One Community
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- O Sibling Leadership Network
- O United Home Care Services Inc. d/b/a United HomeCare
- O West Virginia School of Osteopathic Medicine
- Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

ASSISTANCE DESCRIPTION

What nonmedical volunteer assistance do you, or the person for whom you provide care, receive from this organization? Please select all that apply:

	Respite	care
--	---------	------

- □ I get a break from caregiving
- □ Companionship/friendly visit/reassurance (e.g., inperson, phone check-ins, face-to-face video calls, emails, etc.)
- □ Travel companion/chaperone
- □ Non-emergency medical appointment companion/chaperone
- □ Transportation assistance
- □ Safety checks
- □ Light chores/help around the home
- □ Laundry

- □ Food preparation
- Meal assistance
- Light yard maintenance
- □ Minor home modifications
- □ Grocery shopping
- □ Picking up prescriptions/medical equipment
- □ Other errands
- Peer mentoring
- □ Recreational companion/chaperone
- □ Stress reduction
- □ Emergency preparedness
- □ Other:

How long have you been receiving volunteer assistance from this organization? Please choose only one of the following:

O < 6 months

O 6 months – 18 months O > 18 months

Would it be easy to replace the assistance provided if volunteers from this organization were no longer available? Please choose only one of the following:

O Yes O No

Unsur

We know that caregiving can be hard and stressful from time to time. We hope that participation in this program has helped relieve some of the burden you may be feeling. Please know that your responses to the following questions are private and intended only to let us know if the volunteer assistance you received has been helpful.

EXPERIENCE

Did the person you provide care for benefit from the assistance you received from this organization? Please choose only one of the following:

O Yes O No

O I don't know

Did the volunteer assistance make you feel more capable as a caregiver? Please choose only one of the following:

O Yes

- C
 - O No O I don't know

How difficult is it for you to maintain the current living situation of the person you provide care for? Please choose only one of the following:

O Not at all difficult O Somewhat difficult O Difficult

O Extremely difficult

Community Care Corps Caregiver Post-Survey 2

With the volunteer services in place, I am doing less for the person I provide care for in the following areas: Please choose all that apply:

	Using the telephon Technology/comm Shopping Food preparation Housekeeping Laundry Transportation		ation assistance				Moving Eating Dressin Bathing	ng finances ; in and out of a cha g	ir or	bed
Abo	out how often do yo	ou pr	ovide care for this p	perso	on? Please cho	os	e only c	one of the following		
0	Daily	0	A couple of times per week	0	Weekly		0	A couple of times per month		
Ove	erall, how often do	you	feel stressed by prov	vidir	ng care? Please	e cl	hoose o	only one of the follo	wing	:
0	Never	0	Rarely	0	Sometimes		0	Quite frequently	0	Nearly always
	you having feeling owing:	s of I	being overwhelmed	, ove	er-worked, and	d/c	or overk	ourdened? Please c	hoos	e only one of the
0	All of the time	0	Most of the time	0	Some of the	tir	ne O	Never		
cho	es the assistance the lose only one of the Yes, a lot	follo	ganization provides owing: Yes, some	help	o to relieve sor No, not very much		of the		care	giving? Please
Q	UALITY OF LIFE				inden					
Ηον	w would you rate yo	our c	uality of life? Please	e cho	oose only one	of	the follo	owing:		
0	Very good	0	Good	0	Fair		0	Poor	0	Very poor
	e assistance I receive owing:	e fro	m this organization	imp	roved the qua	lity	y of my	life. Please choose	only	one of the
0	Strongly Agree	0	Somewhat agree	0	Neither agree/disagre	e.	0	Somewhat disagre	еO	Strongly disagree
Dui	ring the past month	, ho	w often have you fe	lt do			blue? Pl	lease choose only o	ne of	the following:
0	All of the time	0	Most of the time	0	Some of the t	im	e O	Never		
Dui	ing the past month	, ho	w often have you fe	lt wo	orried? Please	ch	oose or	nly one of the follow	ving:	
0	All of the time	0	Most of the time	0	Some of the t	im	e O	Never		

During the past month, how often have you felt lonely? Please choose only one of the following: O Most of the time O Some of the time O Never O All of the time Overall, how would you describe your physical health? Please choose only one of the following: O Excellent O Good O Fair O Poor Overall, how would you describe your mental health? Please choose only one of the following: O Excellent O Good O Fair O Poor Thank you for completing this survey. \bigcirc Co ommuni

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.....

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First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

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QUALITY OF LIFE

Ηο	How would you rate your quality of life? Please choose only one of the following:									
0	Very good	0	Good	0	Fair	0	Poor	0	Very poor	
Dui	During the past month, how often have you felt downhearted and blue? Please choose only one of the following:									
0	All of the time	0	Most of the time	0	Some of the time	0	Never			
Dui	During the past month, how often have you felt worried? Please choose only one of the following:									
0	All of the time	0	Most of the time	0	Some of the time	0	Never)	
Dui	ring the past month,	ho	v often have you fel	t lor	nely? Please choose	only	one of the following	g:		
0	All of the time	0	Most of the time	0	Some of the time	0	Never			
Ove	erall, how would you	ı de	scribe your physical	hea	Ith? Please choose o	only	one of the following	:		
0	Excellent	0	Good	0	Fair	0	Poor			
Ov	erall, how would yo	u de	escribe your mental	heal	th? Please choose o	nly	ne of the following:			
0	Excellent	0	Good	0	Fair	0	Poor			
EX	(PERIENCE									
Но	How difficult is it for you to maintain your current living situation? Please choose only one of the following:									
0	Not at all difficult	0	Somewhat difficult	0	Difficult	0	Extremely difficult			

During the past month please rate how much difficulty you've had with each of the following tasks when completed on your own: Please choose the appropriate response for each item:

.

	No Difficulty	Some Difficulty	A Lot of Difficulty	Usually Unable to Do
Eating	0	0	0	0
Dressing	0	0	0	0
Bathing	0	0	0	0
Cleaning	0	0	0	0
Home maintenance	0	0	0	0
Running errands	0	0	0	0
Grocery shopping	0	0	0	0
Doing laundry	0	0	0	0
Preparing meals	0	0	0	0
Walking	0	0	0	0
Standing	0	0	0	0

DEMOGRAPHICS

Wł	hat age did you turn on your last birthday?		
Wł	nat is your employment status? Please choose all that ap	ply:	
	Full-time student		Retired
	Part-time student		Semi-retired
	Employed full-time		Other:
	Employed part-time		6
Wł	nich of these best describe your race and/or ethnicity? P	leas	e choose all that apply:
	American Indian or Alaska Native		Native Hawaiian or Other Pacific Islander
	Asian		White
	Black or African American		Prefer not to answer
	Hispanic, Latino, or Spanish origin		Other:
Wł	nat is your educational level? Please choose only one of t	the	following:
0	Less than High School		S O S
	High School Diploma or Equivalent		
	Some College/Trade School		
	College/Trade School Graduate		
	Post-Graduate Degree		
Wł	nat gender do you identify as? Please choose only one of	the	following:
0	Male		
	Female		
	Non-binary		
	Prefer not to say		
	Other:		
		<i>.</i> .	
Wr	nere do you currently live? Please choose only one of the	e tol	lowing:
Ο	In my own home (e.g., house, apartment, trailer, etc.)		
	Senior Housing		
Ο	Assisted Living Facility		
Ο	Life Plan Community or Continuing Care Retirement Cor	nmı	unity
Ο	In a family member's home		

- O With a friend or roommate
- O In a group home
- O Other: _____

Do you have any family/friends that help take care of you daily or several times a week? (Note - the choices in this lis
include step, foster, and in-laws) Please choose all that apply:

○ Spouse ○ Parent		O Niece/NephewO Cousin	
O Child		O Other Relative	
O Sibling		O Friend	
O Grandparent		O Neighbor	
O Grandchild		O None	
O Aunt/Uncle			
Do you identify as a	person with a disab	bility? Please choose only one of the following:	5
O Yes	O No	O Prefer not to say	$\langle \langle \rangle$
Do you have a long-	term health condition	on? Please choose only one of the following:)
O Yes	O No	O Prefer not to say	
	The	ank you for completing this survey.	

Recipient Post-Survey Welcome to the Community Care Corps Survey!



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Please write your answers here:

First two letters of your FIRST name:

First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

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- O West Virginia School of Osteopathic Medicine
- Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

What nonmedical volum	teer assistance did you rec	eive from this orga	nization? Please select all that apply:
 in-person, phone calls, emails, etc. Travel companio Non-emergency companion/chap Transportation a Respite for my fa Safety checks Light chores/helg Laundry Food preparation 	n/chaperone medical appointment perone ssistance mily caregiver o around the home		Meal assistance Light yard maintenance Minor home modifications Grocery shopping Picking up prescriptions/medical equipment Other errands Peer mentoring Recreational companion/chaperone Stress reduction Emergency preparedness Unsure
following:			
○ < 6 months	O 6 months – 18 C months) > 18 months	S>
	this organization to a frien only one of the following:	nd or family membe	r who could benefit from the assistance it
O Yes	O No C) Unsure	
Would it be easy to repla Please choose only one o		d if volunteers from Unsure	n this organization were no longer available?
EXPERIENCE			
How satisfied are you wi	ith the assistance the volu	nteers provide? Plea	ase choose only one of the following:
O Extremely satisfied	O Somewhat O satisfied	Neither satisfied/dissatisfie	O Somewhat O Extremely d dissatisfied dissatisfied
How difficult is it for you	to maintain your current	living situation? Ple	ease choose only one of the following:
O Not at all difficult	O Somewhat difficult O	Difficult	O Extremely difficult
The assistance provided only one of the following	•	easier for me to ma	aintain my current living situation. Please choose
O Strongly Agree	O Somewhat agree O	Neither agree/disagree	○ Somewhat disagree ○ Strongly disagree

While you were getting volunteer assistance, how much difficulty did you have doing the following tasks on your own? Please choose the appropriate response for each item:

Eating O O O	
.	0
Dressing O O O	0
Bathing O O O	0
Cleaning O O O	0
Home maintenance O O O	0
Running errands O O O	0
Grocery shopping O O O	0
Doing laundry O O O	0
Preparing meals O O O	0
Walking O O O	0
Standing O O O	0
QUALITY OF LIFE	
How would you rate your quality of life? Please choose only one of the following:	
O Very good O Good O Fair O Poor	O Very poor
During the past month, how often have you felt downhearted and blue? Please choose only of	ne of the following:
O All of the time O Most of the time O Some of the time O Never	
During the past month, how often have you felt worried? Please choose only one of the follow	ving:
O All of the time O Most of the time O Some of the time O Never	
During the past month, how often have you felt lonely? Please choose only one of the following	ng:
O All of the time O Most of the time O Some of the time O Never	
Overall, how would you describe your physical health? Please choose only one of the following	g:
O Excellent O Good O Fair O Poor	
Overall, how would you describe your mental health? Please choose only one of the following	5.
O Excellent O Good O Fair O Poor	

Thank you for completing this survey.

Community Care Corps: Volunteer Post-Survey



Welcome to the Community Care Corps Survey!

You are being asked to complete this survey because you volunteer with an organization funded through Community Care Corps. The information you provide is extremely valuable. It helps us understand what makes this organization's program helpful to the community.

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We know your time is valuable and we appreciate you taking some of it to help us with this project!

Please do not skip any of the questions in this section.

.....

In order to keep all the information you give us together we need you to create a participant ID. For example, my name is **Ma**ria **Jo**nes and I was born in 19**71**. My ID is **MAJO71**.

Please write your answer(s) here:

First two letters of your FIRST name:

First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

What organization do you currently volunteer with? Please choose only one of the following:

- O A Little Help
- O Duet: Partners in Health and Aging
- O FamilyMeans
- O Hospice of the Valley
- Institute for Community Equity and Sharing, Inc. dba One Community
- O Jewish Family and Children's Service of Greater Philadelphia
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- O United Home Care Services Inc. d/b/a United HomeCare
- O West Virginia School of Osteopathic Medicine
- Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)



SERVICE DESCRIPTION

What non-medical volunteer assistance have you been providing for this organization? Please select all that apply:

- □ Respite care
- Companionship/friendly visit/reassurance
 (e.g., in-person, phone check-ins, face-to-face
 video calls, emails, etc.)
- □ Travel companion/chaperone
- □ Non-emergency medical appointment companion/chaperone
- □ Transportation assistance
- □ Patient advocacy
- □ Safety checks
- □ Light chores/help around the home
- □ Laundry

- □ Food preparation
- □ Meal assistance
- □ Light yard maintenance
- ☐ Minor home modifications
- Grocery shopping
- Picking up prescriptions/medical equipment
- Other errands
- Peer counseling
- Recreational companion/chaperone
- Stress reduction
- Emergency preparedness
- Unsure

How many hours per week on average do you provide nonmedical volunteer assistance through this organization? Please choose only one of the following:

- O Less than 2.5 hours
- O 2.5 5 hours
- O 6 10 hours
- O 11 15 hours
- O 16 20 hours
- O More than 20 hours

What benefits do you personally get from volunteering? Please choose all that apply:

- □ Keeps me feeling connected to others
- □ Is good for my social well-being
- □ Mental health (e.g., reducing anxiety, depression, stress)
- □ Keeps me learning/growing
- □ Makes me "feel good"
- □ Physical health
- □ Possible connections for career building/resume building
- □ None of the above

How would you describe the nonmedical volunteer assistance you provided? Please choose all that apply:

- □ Satisfying
- Valuable
- Purposeful
- None of the above



Community Care Corps: Volunteer Post-Survey

Did you think the nonmedical volunteer assistance you provided helped community members maintain independence in their homes? Please choose only one of the following:

- O Yes
- O No
- O Unsure

As well as volunteering, do you also receive nonmedical volunteer assistance from this program yourself? Please choose only one of the following:

 Yes No Unsure
Volunteer Demographics
What age did you turn on your last birthday?
What is your employment status? Please choose all that apply:
 Full-time student Part-time student
 Employed full-time Employed part-time
 Retired Semi-retired Other:
Which of these best describe your race and/or ethnicity? Please choose all that apply:

- □ American Indian or Alaska Native
- 🗆 Asian
- □ Black or African American
- □ Hispanic, Latino, or Spanish Origin
- □ Native Hawaiian or Other Pacific Islander
- □ White
- □ Prefer not to say
- □ Other:

Community Care Corps: Volunteer Post-Survey



What is your educational level? Please choose only one of the following:

- O Less than High School
- O High School Diploma or Equivalent

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- O Some College/Trade School
- O College/Trade School Graduate
- O Post-Graduate Degree

What gender do you identify as? Please choose only one of the following:

- O Male
- O Female
- O Non-binary
- O Prefer not to say
- O Other: _____

Thank you for completing this survey

Community Care Corps: One-Time Assistance Survey



Welcome to the Community Care Corps One-Time Assistance Survey!

You are being asked to complete this survey because you received assistance from an organization funded through Community Care Corps. If you have completed this survey before, please do not fill it out again. The information you provide is extremely valuable. It helps us understand what makes this organization's program helpful to the community.

You are not asked to provide your name or other identifying information. All your responses will be kept confidential. Except for your Participant ID, the state you live in, and the organization you are affiliated with, you can skip any questions you do not feel comfortable answering. The information you provide will not impact your ability to receive assistance from this organization.

We know your time is valuable and we appreciate you taking some of it to help us with this project!

Please do not skip any of the questions in this section.

In order to keep all the information you give us together we need you to create a participant ID. For example, my name is **Ma**ria **Jo**nes and I was born in 1971. My ID is **MAIO71**.

Please write your answer(s) here:

First two letters of your FIRST name:

First two letters of your LAST name:

Last two numbers of your BIRTH year:

What state do you currently live in?

What organization do you currently receive assistance from? Please choose only one of the following:

- O A Little Help
- O Duet: Partners in Health and Agir
- O FamilyMeans
- O Hospice of the Valley
- Institute for Community Equity and Sharing, Inc. dba One Community
- O Jewish Family and Children's Service of Greater O SAGE Philadelphia
- O Lifespan of Greater Rochester
- O Lutheran Senior Services
- O MAB Community Services
- O NeighborLink Indianapolis Foundation Inc
- O On My Own of Michigan
- O CaringMatters
- O Peninsula Agency on Aging

- O Penn Memory Center, University of Pennsylvania
- O Prisma Health–Upstate
- O REACH Community Respite Ministry
- O Rebuilding Together New Orleans
- O SeniorAge
- O Sibling Leadership Network
- O United Home Care Services Inc. d/b/a United HomeCare
- O West Virginia School of Osteopathic Medicine
- O Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)



SERVICE DESCRIPTION

What type of one-time assistance did you receive from this organization? Please select all that apply:

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- □ Home modifications (e.g., installing grab bars)
- □ Assistance accessing resources and programs
- □ Virtual conversations on caregiving topics
- □ Yard work and landscaping
- □ Virtual reality experiences
- □ Meal delivery services
- □ Therapy pet visits
- □ Home repairs
- Other:_____

How much does the one-time volunteer assistance this organization provides help alleviate a major concern in your life? Please choose only one of the following:

- O A lot
- O Some
- O Not very much
- O Not at all

Would it be easy to replace the one-time volunteer assistance if it was not available from this organization? Please choose only one of the following:

- O Yes
- O No
- onnik O Unsure

Community Care Corps: One-Time Assistance Survey



DEMOGRAPHICS
What age did you turn on your last birthday?
What is your employment status? Please select all that apply:
 Full-time student Part-time student Employed full-time Employed part-time Retired Semi-retired Other:
Which of these best describe your race and/or ethnicity? Please select all that apply:
 American Indian or Alaska Native Asian Black or African American Hispanic, Latino, or Spanish Origin Native Hawaiian or Other Pacific Islander White Prefer not to answer Other:
What is your educational level? Please choose only one of the following:
 Less than High School High School Diploma or Equivalent. Some College/Trade School College/Trade School Graduate Post-Graduate Degree
What gender do you identify as? Please choose only one of the following:
 Male Female Non-binary Prefer not to say Other:

Community Care Corps: One-Time Assistance Survey



Where do you currently live? Please choose only one of the following:

- O In my own home (e.g., house, apartment, trailer, etc.)
- O Senior Housing
- O Assisted Living Facility
- O Life Plan Community or Continuing Care Retirement Community
- O In a family member's home
- O With a friend or roommate
- O In a group home
- O Other:____

Do you have any family/friends that help take care of you daily or several times a week? (Note – the choices in this list include step, foster, and in-laws.) Please select all that apply:

□ Spouse □ Cousin □ Parent □ Another relative □ Child □ Friend □ Sibling □ Neighbor □ Grandparent □ None □ Grandchild □ Aunt/Uncle □ Niece/Nephew Do you identify as a person with a disability? Please choose only one of the following: O Yes O No O Prefer not to say Do you have a long-term health condition? Please choose only one of the following: O Yes O No O Prefer not to sa

Thank you for completing this survey!