Caregiver Pre-Survey

Welcome to the Community Care Corps Survey!

You are being asked to complete this survey because you receive assistance from 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.

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!

.....

*The following section is **MANDATORY**.*

In order to keep all the information you give us together we need you to create a participant ID. Your ID will be the first two letters of your first name, the first two letters of your last name, and the last two numbers of your birth year.

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? _____

What organization is assisting you? Please choose **only one** of the following:

- ○ A Little Help
- ○ CaringMatters
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ 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

How would you rate your quality of life? Please choose only **one** of the following:

○ Very good ○ Good ○ Fair ○ Poor ○ Very poor

During the past month, how often have you felt downhearted and blue? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt worried? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt lonely? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

Overall, how would you describe your physical health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

Overall, how would you describe your mental health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

EXPERIENCE

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:

○ Not at all difficult ○ Somewhat difficult ○ Difficult ○ Extremely difficult

How often do you feel capable as a caregiver? Please choose only one of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

I assist the person I provide care for with the following: Please choose **all** that apply:

☐ Using the telephone
☐ Technology/communication assistance
☐ Shopping
☐ Food preparation
☐ Housekeeping
☐ Laundry
☐ Transportation
☐ Medications
☐ Handling finances
☐ Moving in and out of a chair or bed
☐ Eating
☐ Dressing
☐ Bathing
☐ Walking/mobility

About how often do you provide care for this person? Please choose only **one** of the following:

○ Daily ○ A couple of times per week ○ Weekly ○ A couple of times per month

Overall, how often do you feel stressed by providing care? Please choose only **one** of the following:

○ Never ○ Rarely ○ Sometimes ○ Quite frequently ○ Nearly always

Are you having feelings of being overwhelmed, over-worked, and/or overburdened? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

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

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
☐ 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: _____

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

- ○ Spouse
- ○ Parent
- ○ Child
- ○ Sibling
- ○ Grandparent
- ○ Grandchild
- ○ Aunt/Uncle
- ○ Niece/Nephew
- ○ Cousin
- ○ Other Relative
- ○ Friend
- ○ Neighbor

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

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

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

○ Yes ○ No ○ Prefer not to say

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

○ Yes ○ No ○ Prefer not to say

Thank you for completing this survey.

Caregiver Post-Survey

Welcome to the Community Care Corps Survey!

You are being asked to complete this survey because you receive assistance from 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.

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!

.....

*The following section is **MANDATORY.***

In order to keep all the information you give us together we need you to create a participant ID. Your ID will be the first two letters of your first name, the first two letters of your last name, and the last two numbers of your birth year.

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? _____

What organization is assisting you? Please choose **only one** of the following:

- ○ A Little Help
- ○ CaringMatters
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ 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., in-person, 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:

○ < 6 months ○ 6 months – 18 months ○ > 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:

○ Yes ○ No ○ Unsure

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:

○ Yes ○ No ○ I don't know

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

○ Yes ○ No ○ 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:

○ Not at all difficult ○ Somewhat difficult ○ Difficult ○ Extremely difficult

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 telephone
- ☐ Technology/communication assistance
- ☐ Shopping
- ☐ Food preparation
- ☐ Housekeeping
- ☐ Laundry
- ☐ Transportation
- ☐ Medications
- ☐ Handling finances
- ☐ Moving in and out of a chair or bed
- ☐ Eating
- ☐ Dressing
- ☐ Bathing
- ☐ Walking/mobility

About how often do you provide care for this person? Please choose only **one** of the following:

○ Daily ○ A couple of times per week ○ Weekly ○ A couple of times per month

Overall, how often do you feel stressed by providing care? Please choose only **one** of the following:

○ Never ○ Rarely ○ Sometimes ○ Quite frequently ○ Nearly always

Are you having feelings of being overwhelmed, over-worked, and/or overburdened? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

Does the assistance this organization provides help to relieve some of the stress or burden of caregiving? Please choose only **one** of the following:

○ Yes, a lot ○ Yes, some ○ No, not very much ○ No, not at all

QUALITY OF LIFE

How would you rate your quality of life? Please choose only **one** of the following:

○ Very good ○ Good ○ Fair ○ Poor ○ Very poor

The assistance I receive from this organization improved the quality of my life. Please choose only **one** of the following:

○ Strongly Agree ○ Somewhat agree ○ Neither agree/disagree ○ Somewhat disagree ○ Strongly disagree

During the past month, how often have you felt downhearted and blue? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt worried? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt lonely? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

Overall, how would you describe your physical health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

Overall, how would you describe your mental health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

Thank you for completing this survey.

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

You are being asked to complete this survey because you receive assistance from 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.

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!

.....

*The following section is **MANDATORY**.*

In order to keep all the information you give us together we need you to create a participant ID. Your ID will be the first two letters of your first name, the first two letters of your last name, and the last two numbers of your birth year.

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? _____

What organization is assisting you? Please choose **only one** of the following:

- ○ A Little Help
- ○ CaringMatters
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ West Virginia School of Osteopathic Medicine
- ○ Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

QUALITY OF LIFE

How would you rate your quality of life? Please choose only **one** of the following:

○ Very good ○ Good ○ Fair ○ Poor ○ Very poor

During the past month, how often have you felt downhearted and blue? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt worried? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt lonely? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

Overall, how would you describe your physical health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

Overall, how would you describe your mental health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

EXPERIENCE

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

○ Not at all difficult ○ Somewhat difficult ○ Difficult ○ 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	○	○	○	○
Dressing	○	○	○	○
Bathing	○	○	○	○
Cleaning	○	○	○	○
Home maintenance	○	○	○	○
Running errands	○	○	○	○
Grocery shopping	○	○	○	○
Doing laundry	○	○	○	○
Preparing meals	○	○	○	○
Walking	○	○	○	○
Standing	○	○	○	○

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 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: _____

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

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

- ○ Spouse
- ○ Parent
- ○ Child
- ○ Sibling
- ○ Grandparent
- ○ Grandchild
- ○ Aunt/Uncle
- ○ Niece/Nephew
- ○ Cousin
- ○ Other Relative
- ○ Friend
- ○ Neighbor
- ○ None

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

○ Yes ○ No ○ Prefer not to say

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

○ Yes ○ No ○ Prefer not to say

Thank you for completing this survey.

Recipient Post-Survey

Welcome to the Community Care Corps Survey!

You are being asked to complete this survey because you receive assistance from 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.

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!

.....

*The following section is **MANDATORY.***

In order to keep all the information you give us together we need you to create a participant ID. Your ID will be the first two letters of your first name, the first two letters of your last name, and the last two numbers of your birth year.

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? _____

What organization is assisting you? Please choose **only one** of the following:

- ○ A Little Help
- ○ CaringMatters
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ West Virginia School of Osteopathic Medicine
- ○ Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

What nonmedical volunteer assistance did you receive from this organization? Please select **all** that apply:

- ☐ 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
- ☐ Respite for my family caregiver
- ☐ 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
- ☐ Unsure

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

○ < 6 months ○ 6 months – 18 months ○ > 18 months

Would you recommend this organization to a friend or family member who could benefit from the assistance it offered? Please choose only **one** of the following:

○ Yes ○ No ○ Unsure

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:

○ Yes ○ No ○ Unsure

EXPERIENCE

How satisfied are you with the assistance the volunteers provide? Please choose only **one** of the following:

○ Extremely satisfied ○ Somewhat satisfied ○ Neither satisfied/dissatisfied ○ Somewhat dissatisfied ○ Extremely dissatisfied

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

○ Not at all difficult ○ Somewhat difficult ○ Difficult ○ Extremely difficult

The assistance provided by the volunteers made it easier for me to maintain my current living situation. Please choose only **one** of the following:

○ Strongly Agree ○ Somewhat agree ○ 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:

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

QUALITY OF LIFE

How would you rate your quality of life? Please choose only **one** of the following:

○ Very good ○ Good ○ Fair ○ Poor ○ Very poor

During the past month, how often have you felt downhearted and blue? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt worried? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

During the past month, how often have you felt lonely? Please choose only **one** of the following:

○ All of the time ○ Most of the time ○ Some of the time ○ Never

Overall, how would you describe your physical health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ Poor

Overall, how would you describe your mental health? Please choose only **one** of the following:

○ Excellent ○ Good ○ Fair ○ 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.

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 volunteer with 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 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:

- ○ A Little Help
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ CaringMatters
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ West Virginia School of Osteopathic Medicine
- ○ Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

Community Care Corps: Volunteer Post-Survey

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:

- ○ Less than 2.5 hours
- ○ 2.5 – 5 hours
- ○ 6 – 10 hours
- ○ 11 – 15 hours
- ○ 16 – 20 hours
- ○ 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:

- ○ Yes
- ○ No
- ○ 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:

- ○ 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: _____

……

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 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 receive assistance from? Please choose **only one** of the following:

- ○ A Little Help
- ○ Duet: Partners in Health and Aging
- ○ FamilyMeans
- ○ Hospice of the Valley
- ○ Institute for Community Equity and Sharing, Inc. dba One Community
- ○ Jewish Family and Children's Service of Greater Philadelphia
- ○ Lifespan of Greater Rochester
- ○ Lutheran Senior Services
- ○ MAB Community Services
- ○ NeighborLink Indianapolis Foundation Inc
- ○ On My Own of Michigan
- ○ CaringMatters
- ○ Peninsula Agency on Aging
- ○ Penn Memory Center, University of Pennsylvania
- ○ Prisma Health–Upstate
- ○ REACH Community Respite Ministry
- ○ Rebuilding Together New Orleans
- ○ SeniorAge
- ○ SAGE
- ○ Sibling Leadership Network
- ○ United Home Care Services Inc. d/b/a United HomeCare
- ○ West Virginia School of Osteopathic Medicine
- ○ Yellowstone Council on Aging (YCOA) dba Adult Resource Alliance of Yellowstone County (ARA)

Community Care Corps: One-Time Assistance Survey

……

SERVICE DESCRIPTION

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

☐ 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:

○ A lot
○ Some
○ Not very much
○ 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:

○ Yes
○ No
○ 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:

- ○ In my own home (e.g., house, apartment, trailer, etc.)
- ○ Senior Housing
- ○ Assisted Living Facility
- ○ Life Plan Community or Continuing Care Retirement Community
- ○ In a family member's home
- ○ With a friend or roommate
- ○ In a group home
- ○ 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
- ☐ Parent
- ☐ Child
- ☐ Sibling
- ☐ Grandparent
- ☐ Grandchild
- ☐ Aunt/Uncle
- ☐ Niece/Nephew
- ☐ Cousin
- ☐ Another relative
- ☐ Friend
- ☐ Neighbor
- ☐ None

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

- ○ Yes
- ○ No
- ○ Prefer not to say

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

- ○ Yes
- ○ No
- ○ Prefer not to say

.....

Thank you for completing this survey!