

# Davie County Community Health Survey

## PART 1: Quality of Life Statements

The first questions are about how you see certain parts of Davie County life. Please tell us whether you “strongly disagree”, “disagree”, “agree” or “strongly agree” with each of the next 6 statements.

Statements	Choose a number for each statement below.			
	Strongly Disagree	Disagree	Agree	Strongly Agree
1. Think about this statement, “There is a good healthcare system in Davidson County”. Think about the options you have for healthcare, how easy it is to get in the door, the cost and quality.	1	2	3	4
2. Think about this statement, “Davidson County is a good place to raise children”. Think about the quality and safety of the schools and day cares, after school programs, places to play.	1	2	3	4
3. Think about this statement, “Davidson County is a good place to grow old”. Think about elder-friendly housing, transportation to medical services, recreation, elder day care, social support for the elderly living alone, meals on wheels.	1	2	3	4
4. Think about this statement, “There is plenty of economic opportunity in Davidson County”. Think the number and quality of jobs, job training/higher education opportunities, affordable housing.	1	2	3	4
5. Think about this statement, “Davidson County is a safe place to live”. Think about safety at home, in the workplace, in schools, at playgrounds, parks, shopping centers.	1	2	3	4
6. Think about this statement, “There is plenty of support and help for individuals and families during times of stress and need in Davidson County”. Examples include neighbors, support groups, faith community outreach, agencies, organizations, emergency monetary assistance.	1	2	3	4

## PART 2: Community Problems and Issues

### Health Problems

1. These next questions are about health problems that individual people have that have the largest impact on the community as a whole. Please look at this list of health problems. I would like for you to pick the 5 most important health problems in Davie County. Remember this is your opinion and your choices will not be linked to you in any way. If you do not see a health problem you consider one of the most important 5, please let me know and I will type it in. I can also read these out loud as you think about them.

- |                                                                                                      |                                                                                                              |                                                                                         |
|------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------|
| <input type="checkbox"/> Aging problems<br>(Alzheimer's, arthritis,<br>hearing or vision loss, etc.) | <input type="checkbox"/> HIV/AIDS                                                                            | <input type="checkbox"/> Other Injuries (drowning,<br>choking, home or work<br>related) |
| <input type="checkbox"/> Asthma                                                                      | <input type="checkbox"/> Infant death                                                                        | <input type="checkbox"/> Obesity/overweight                                             |
| <input type="checkbox"/> Birth defects                                                               | <input type="checkbox"/> Infectious/Contagious<br>diseases (TB, salmonella,<br>pneumonia, flu, etc.)         | <input type="checkbox"/> Lung disease<br>(emphysema, etc.)                              |
| <input type="checkbox"/> Cancer<br>What kind? _____                                                  | <input type="checkbox"/> Kidney disease                                                                      | <input type="checkbox"/> Sexually transmitted<br>diseases (STDs)                        |
| <input type="checkbox"/> Dental Health                                                               | <input type="checkbox"/> Liver Disease                                                                       | <input type="checkbox"/> Stroke                                                         |
| <input type="checkbox"/> Diabetes                                                                    | <input type="checkbox"/> Mental health (depression,<br>schizophrenia, etc.)                                  | <input type="checkbox"/> Teenage pregnancy                                              |
| <input type="checkbox"/> Gun-related injuries                                                        | <input type="checkbox"/> Motor vehicle accidents                                                             | <input type="checkbox"/> Other _____                                                    |
| <input type="checkbox"/> Heart disease/heart attacks                                                 | <input type="checkbox"/> <b>Neurological disorders</b><br>(Multiple sclerosis,<br>muscular dystrophy, A.L.S) |                                                                                         |
| <input type="checkbox"/> <b>Autism</b>                                                               |                                                                                                              |                                                                                         |

### Unhealthy Behaviors

2. These next questions are about unhealthy behaviors that individual people do that have the largest impact on the community as a whole. Please look at this list of unhealthy behaviors. **Pick the 5 biggest unhealthy behaviors in Davie County**. Remember this is your opinion and your choices will not be linked to you in any way. If you do not see an unhealthy behavior that you consider one of the most important 5, please let me know and I will type it in. I can also read these out loud as you think about them.

- |                                                                                    |                                                                                            |                                                     |
|------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> Alcohol Abuse                                             | <input type="checkbox"/> Not using seat belts                                              | <input type="checkbox"/> Poor eating habits         |
| <input type="checkbox"/> Drug Abuse                                                | <input type="checkbox"/> Not going to a dentist for<br>preventive check ups and<br>care    | <input type="checkbox"/> Reckless/drunk driving     |
| <input type="checkbox"/> Having unsafe sex                                         | <input type="checkbox"/> Not going to the doctor for<br>yearly check ups and<br>screenings | <input type="checkbox"/> Smoking/tobacco use        |
| <input type="checkbox"/> Lack of exercise                                          | <input type="checkbox"/> Not getting prenatal<br>(pregnancy) care.                         | <input type="checkbox"/> Suicide                    |
| <input type="checkbox"/> Not getting immunizations<br>("shots") to prevent disease |                                                                                            | <input type="checkbox"/> Violent behavior           |
| <input type="checkbox"/> Not using child safety seats                              |                                                                                            | <input type="checkbox"/> <b>Rape/sexual assault</b> |
|                                                                                    |                                                                                            | <input type="checkbox"/> <b>Domestic Violence</b>   |
|                                                                                    |                                                                                            | <input type="checkbox"/> Other: _____               |

## Community Issues

**3. These next questions are about community-wide issues that have the largest impact on the overall quality of life in Davie County. Please look at this list of community issues. Pick the 5 community issues that have the greatest effect on quality of life in Davie County. Remember this is your opinion and your choices will not be linked to you in any way. If you do not see a community problem you consider one of the most important 5, please let me know and I will type it in. I can also read these out loud as you think about them.**

- |                                                                                                   |                                                                |
|---------------------------------------------------------------------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Animal control issues                                                    | <input type="checkbox"/> Neglect and abuse (Specify type)      |
| <input type="checkbox"/> Availability of child care                                               | <input type="checkbox"/> Elder abuse                           |
| <input type="checkbox"/> Affordability of health services                                         | <input type="checkbox"/> Child Abuse                           |
| <input type="checkbox"/> Availability of healthy food choices                                     | <input type="checkbox"/> Domestic violence                     |
| <input type="checkbox"/> Bioterrorism                                                             | <input type="checkbox"/> Pollution (air, water, land)          |
| <input type="checkbox"/> Dropping out of school                                                   | <input type="checkbox"/> Low income/poverty                    |
| <input type="checkbox"/> Homelessness                                                             | <input type="checkbox"/> Racism                                |
| <input type="checkbox"/> Inadequate/unaffordable housing                                          | <input type="checkbox"/> Transportation options                |
| <input type="checkbox"/> Lack of/inadequate health insurance                                      | <input type="checkbox"/> Unemployment                          |
| <input type="checkbox"/> Lack of culturally appropriate services for minorities.                  | <input type="checkbox"/> Unsafe, un-maintained roads           |
| <input type="checkbox"/> Lack of health care providers                                            | <input type="checkbox"/> Violent crime (murder, assault, etc.) |
| What kind? _____                                                                                  | <input type="checkbox"/> Rape/sexual assault                   |
| <input type="checkbox"/> Lack of recreational facilities (parks, trails, community centers, etc.) | <input type="checkbox"/> Domestic Violence                     |
| <input type="checkbox"/> Healthy Family Activities                                                | <input type="checkbox"/> Other: _____                          |
| <input type="checkbox"/> Positive teen activities                                                 |                                                                |

**4. In the past 12 months, did you have a difficult time finding community services that would assist with rent, mortgage, or utility payments?**

Yes                       No

If yes, what was the main reason you had this problem

Lack of Information       Service Not Available       Language or Cultural Barrier

**5. Have you ever received assistance in paying household bills from any of these organizations? (Check all that apply. If none, skip to Part 4.)**

Davie County Department of Social Services       The Advocacy Center  
 The Salvation Army       United Way  
 Have never received assistance

**6. For what bill did you receive assistance?**

Rent                       Mortgage                       Water                       Power

Other: \_\_\_\_\_

**7. When?**

within the past 12 months       1 – 2 years ago       2 + years ago

### PART 3: Personal Health

Now I am going to ask you some questions about your own personal health. Remember, the answers you give for this survey will not be linked to you in any way.

1. How would rate your own personal health? Please choose only one of the following ratings:

Very healthy                       Unhealthy  
 Healthy                                 Very unhealthy  
 Somewhat healthy

2. During the past 12 months, was there any time that you did not have any health insurance or coverage?

yes                       no

3. Where do you get most of your health-related information? Please choose only one.

Friends and family                       Hospital                       School  
 Doctor/nurse/pharmacist                       Help lines                       Church  
 Internet                       Books/ magazines

4. Where do you go most often when you are sick or need advice about your health?

Doctor's office                       A Storehouse for Jesus Medical Clinic  
 Health department                       Urgent Care Center  
 Hospital                       Other: \_\_\_\_\_

5. In what city or town is this place? \_\_\_\_\_

6. About how long has it been since you last visited a doctor for a routine checkup? This does not include any times you visited the doctor because you were sick or pregnant.

Within the past year  
 1-2 years ago  
 3-5 years ago  
 5 or more years ago  
 I have never had a routine checkup.

7. Have you had your blood pressure or cholesterol checked in the last 12 months?

Blood pressure  yes  no      Cholesterol  yes  no

8. In the past 12 months, did you have a problem getting the health care you needed?

Yes                       No (If no, skip to question #10)

9. **Since you said “yes”, which of these problems did you have? You can choose as many of these as you need to. If there was a problem you had that we do not have here, please tell us and I will write it in.**

I didn't have health insurance.  
 My insurance didn't cover what I needed.  
 My share of the cost (deductible/co-pay) was too high.  
 Doctor would not take my insurance or Medicaid.  
 Hospital would not take my insurance.  
 I didn't have a way to get there.  
 I didn't know where to go.  
 I couldn't get an appointment.  
 Other: \_\_\_\_\_

10. **In the past 12 months, did you have a problem filling a medically necessary prescription?**

Yes  No (*If no, skip to question #12*)

11. **Since you said “yes”, which of these problems did you have? You can choose as many of these as you need to. If there was a problem you had that we do not have here, please tell us and I will write it in.**

I didn't have health insurance.  
 My insurance didn't cover what I needed.  
 My share of the cost (deductible/co-pay) was too high.  
 Pharmacy would not take my insurance or Medicaid.  
 I didn't have a way to get there.  
 I didn't know where to go.  
 Other: \_\_\_\_\_

12. **About how long has it been since you last visited a dentist for a routine checkup? Do not include times you visited the dentist because of an emergency. Here are the possibilities. *Read responses. Which do you think best fits you?***

Within the past year.  
 1-2 years ago  
 3-5 years ago  
 5 or more years ago  
 I have never been to a dentist for a routine checkup.

13. **Was there a time during the past 12 months when you needed to get dental care, but could not?**

Yes  No (*If no, skip to question #15*)

14. **Since you said “yes”, why could you not get dental care? You can choose as many of these as you need to. If there was a problem you had that we do not have here, please tell us and I will write it in.**

I didn't have dental insurance.  I didn't have a way to get there.  
 My insurance didn't cover what I needed.  I didn't know where to go.  
 I couldn't afford the cost.  I couldn't get an appointment.  
 Dentist would not take my insurance or Medicaid.  Other: \_\_\_\_\_

15. If a friend or family member needed counseling for a mental health or a drug/alcohol abuse problem, where would you refer them? Here are some possibilities. *Read responses.*

- |                                                      |                                                            |
|------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Triumph                     | <input type="checkbox"/> Private counselor or therapist    |
| <input type="checkbox"/> DayMark                     | <input type="checkbox"/> School counselor                  |
| <input type="checkbox"/> Care-Net                    | <input type="checkbox"/> Support group (e.g., AA, Al-Anon) |
| <input type="checkbox"/> Minister/religious official | <input type="checkbox"/> Other: _____                      |
| <input type="checkbox"/> Doctor                      | <input type="checkbox"/> Don't know                        |

16. Did you receive a flu shot this past flu season? yes no

If yes, where did you receive the shot?

- |                                                       |                                                                        |
|-------------------------------------------------------|------------------------------------------------------------------------|
| <input type="checkbox"/> Health Department flu clinic | <input type="checkbox"/> Private Doctor                                |
| <input type="checkbox"/> Workplace                    | <input type="checkbox"/> Retail facility, i.e. pharmacy, grocery store |

If no, why did you not receive the flu shot?

- |                                       |                               |                                                    |                                |
|---------------------------------------|-------------------------------|----------------------------------------------------|--------------------------------|
| <input type="checkbox"/> Did not want | <input type="checkbox"/> Cost | <input type="checkbox"/> Unavailability of vaccine | <input type="checkbox"/> Other |
|---------------------------------------|-------------------------------|----------------------------------------------------|--------------------------------|

17. In the past 12 months have you or a member of your family needed any of the following **community services**? Please put a check in the box or boxes that most accurately describe what problem(s), if any, you had with the service.

<b>COMMUNITY SERVICE</b>	<b>LACK Of INFORMATION</b> <i>(Didn't know about/couldn't locate information about the service)</i>	<b>COST</b> <i>(Service was too expensive or provider wouldn't accept my insurance)</i>	<b>SERVICE NOT AVAILABLE</b> <i>(It took too long to get an appointment; provider wasn't taking new patients or enrollees; inconvenient location or hours of operation)</i>	<b>LANGUAGE or CUTURAL BARRIER</b> <i>(Service was not sensitive to my language or culture needs)</i>	<b>NO PROBLEM</b> <i>(My family used this service but didn't have any problem accessing or using it)</i>	<b>DID NOT NEED THE SERVICE</b> <i>(My family hasn't needed this service in the past 12 months)</i>
<b>Child care facility for infants or preschoolers</b>						
<b>Educational programs for pre-school children</b>						
<b>After school care for children</b>						
<b>Adult day care / respite care</b>						
<b>Assistance with subsidized housing</b>						
<b>Assistance with food costs / food stamps</b>						
<b>Transportation</b>						
<b>Parenting skills education programs</b>						
<b>Health promotion/wellness program</b>						
<b>Domestic Violence Services</b>						
<b>Legal services</b> <b>Adult Education services</b> <i>(GED, ESL, etc...)</i> <b>Financial Planning/Budgeting</b> <b>Veterans Services</b>						
<b>Other</b> <i>(please write in answer)</i>						

18. In the past 12 months have you or a member of your family needed any of the following **health services**? Please put a check in the box or boxes that most accurately describe what problem(s), if any, you had with the service.

<b>HEALTH SERVICE</b>	<b>LACK Of INFORMATION</b> <i>(Didn't know about/couldn't locate information about the service)</i>	<b>COST</b> <i>(Service was too expensive or provider wouldn't accept my insurance)</i>	<b>SERVICE NOT AVAILABLE</b> <i>(It took too long to get an appointment; provider wasn't taking new patients/enrollees; inconvenient location or hours of operation)</i>	<b>LANGUAGE or CUTURAL BARRIER</b> <i>(Service was not sensitive to my language or culture needs)</i>	<b>NO PROBLEM WITH THIS SERVICE</b> <i>(My family used this service but didn't have any problem accessing or using it)</i>	<b>DID NOT NEED THE SERVICE</b> <i>(My family hasn't needed this service in the past 12 months)</i>
<i>Emergency medical care</i>						
<i>Hospital care</i>						
<i>Pregnancy care</i>						
<i>Enrolling in Medicaid or Medicare</i>						
<i>Mental health care or counseling</i>						
<i>Drug or alcohol treatment program</i>						
<i>Rehabilitation for an injury or permanent physical disability</i>						
<i>Home health care</i>						
<i>Hospice (end-of-life care)</i>						
<i>Long-term care (e.g. nursing home)</i>						
<i>Nutrition service (e.g. Meals on Wheels)</i>						
<i>Purchasing medical equipment</i>						
<b>Veteran's Medical Services</b>						
<b>Early Intervention Services for children</b>						
<b>Other</b> <i>(please write in answer)</i>						

19. **During the past 30 days, other than in your regular job, did you engage in any exercise activity that lasted at least a half an hour?**

Yes  No (If no, skip to question #22)

20. **Since you said yes, how many times would you say you engaged in this activity in the past 30 days? \_\_\_\_\_**

21. **Where do you go to engage in exercise/physical activities? Check all that apply.**

<input type="checkbox"/> Davie Family YMCA	<input type="checkbox"/> Curves
<input type="checkbox"/> Rich Park	<input type="checkbox"/> Home
<input type="checkbox"/> Gym 365	<input type="checkbox"/> D.C. Senior Services
<input type="checkbox"/> Parks & Recreation Gym (Brock Gym)	<input type="checkbox"/> Other: _____

22. **Since you said “no”, why didn’t you? You can give as many of these reasons as you need to.**

<input type="checkbox"/> My job is physical or hard labor	<input type="checkbox"/> I don’t like to exercise.
<input type="checkbox"/> Exercise is not important to me.	<input type="checkbox"/> It costs too much to exercise (equipment, shoes, gym costs)
<input type="checkbox"/> I don’t have access to a facility that has the things I need, like a pool, golf course, or a track.	<input type="checkbox"/> There is no safe place to exercise.
<input type="checkbox"/> I don’t have enough time to exercise.	<input type="checkbox"/> I’m too tired to exercise.
<input type="checkbox"/> I would need child care and I don’t have it.	<input type="checkbox"/> I’m physically disabled.
<input type="checkbox"/> I don’t know how to find exercise partners or teams.	<input type="checkbox"/> I don’t know
	<input type="checkbox"/> Other _____

23. **Not counting juice, think about how often you eat fruit in an average week. How many servings per week would you say you eat?**

Number of servings \_\_\_\_\_

24. **Not counting lettuce salad and potato products, think about how often you eat vegetables in an average week. How many servings per week would you say you eat?**

Number of servings \_\_\_\_\_

25. **Think back to the past 30 days. How many days out of the last 30 did you drink alcohol of any kind?**

Number of days: \_\_\_\_\_

26. **And how many times during the past 30 days did you have more than 5 drinks in a day?**

Number of times: \_\_\_\_\_

27. **Do you smoke cigarettes? (If no or used to, skip to question 29.)**

never  
 I used to smoke but have quit  
 I smoke occasionally (less than one cigarette per day)  
 I smoke one (1) pack or less a day  
 I smoke more than one (1) pack a day. How many packs per day? \_\_\_\_\_

**28. If you currently smoke, where would you go for help in order to quit?**

- |                                                                 |                                                               |
|-----------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> I don't smoke or use smokeless tobacco | <input type="checkbox"/> Quit Now NC                          |
| <input type="checkbox"/> Doctor                                 | <input type="checkbox"/> Health Department                    |
| <input type="checkbox"/> Church                                 | <input type="checkbox"/> I don't know                         |
| <input type="checkbox"/> Pharmacy                               | <input type="checkbox"/> Other: _____                         |
| <input type="checkbox"/> Private counselor/therapist            | <input type="checkbox"/> Not applicable; I don't want to quit |

**29. Where are you exposed to secondhand smoke?**

- |                                      |                                                                |
|--------------------------------------|----------------------------------------------------------------|
| <input type="checkbox"/> Home        | <input type="checkbox"/> School                                |
| <input type="checkbox"/> Workplace   | <input type="checkbox"/> Other: _____                          |
| <input type="checkbox"/> Hospitals   | <input type="checkbox"/> I am not exposed to secondhand smoke. |
| <input type="checkbox"/> Restaurants |                                                                |

**30. Are you in support of tobacco free environments (e.g. schools, hospitals, restaurants)?**

- Yes                       No

**31. How often do you currently use chewing tobacco or snuff (smokeless tobacco)?**

- Every day                       On some days                       Not at all

**32. Have you ever been told by a doctor, nurse, or other health professional that you have any of the conditions I am about to read?**

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Asthma                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Depression                      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High blood pressure             | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| High cholesterol                | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Diabetes (not during pregnancy) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Osteoporosis                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Overweight/Obesity              | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

**33. If you are a male age 40 or older, do you have an annual prostate exam?**

- Yes                       No                       Not applicable (I'm a female, or a male under age 40)

**34. If you are a female age 40 or older, do you have an annual mammogram?**

- Yes                       No                       Not applicable (I'm a male, or a female under age 40)

**35. If you are a female age 21 or older, do you have a pap smear at least every other year?**

- Yes                       No                       Not applicable (I'm a male, or a female under age 21).

**36. Males and females: If you are age 50 or older, have you ever had a colon cancer screening?**

- Yes                       No                       Not applicable (I'm under age 50)

37. I am going to read a list of people you may be taking care of in your home. Please say if you are caring for the following people. If there is another that you are providing care for, let me know and I will write it in. Here is the list: (If no, go to question #37)

Elderly or disabled Parent       Disabled spouse       Disabled child  
 Grandchild       Foster child(ren)       Other: \_\_\_\_\_

38. In the past 12 months, did you have a difficult time finding care for the person or people indicated above?

Yes       No

If yes, what was the main reason you had this problem? \_\_\_\_\_

39. Do you have children between the ages of 9 and 19?

Yes       No (now skip to question #41)

40. Do you think your child is engaging in any of the following high risk behaviors:

Alcohol Use       Eating Disorders       Drug Abuse  
 Tobacco Use       Sexual intercourse       Reckless driving/speeding  
 I don't think my child is engaging in any high risk behaviors.

41. Are you comfortable talking to your child about the risky behaviors we just asked about?

Yes       No

42. Do you think your child or children need more information about the following problems?

Alcohol       Eating Disorders       Drug Abuse  
 Tobacco       Sexual intercourse       Reckless driving/speeding  
 HIV       STDs       Mental health issues

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## Part 4. Demographic Questions

The next set of questions are very general questions about you, but they let us see how different types of people view different health issues.

1. Do you work or go to school in Davie County?

yes       no

2. How old are you?

18 - 20       26 - 39       55 - 64  
 21 - 25       40 - 54       65 or older

3. Are you Male or Female? \_\_\_\_\_ Male \_\_\_\_\_ Female

4. What is your race or ethnicity?

\_\_\_\_\_ African American/Black

\_\_\_\_\_ Native American

\_\_\_\_\_ Asian/Pacific Islander

\_\_\_\_\_ White/Caucasian

\_\_\_\_\_ Hispanic/Latino

\_\_\_\_\_ Other: \_\_\_\_\_

5. What is your marital status?

\_\_\_\_\_ Never Married/Single \_\_\_\_\_ Divorced

\_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_ Other

6. What is the highest level of school, college or training that you have finished?

\_\_\_\_\_ Less than high school

\_\_\_\_\_ High school diploma or GED

\_\_\_\_\_ Associate's Degree or Vocational Training

\_\_\_\_\_ College degree

\_\_\_\_\_ Graduate degree or higher

\_\_\_\_\_ Other: \_\_\_\_\_

7. What was your total household income last year, before taxes? I will read out 5 categories. Let me know which you fall into.

\_\_\_\_\_ Less than \$20,000

\_\_\_\_\_ \$50,000 to \$74,999

\_\_\_\_\_ \$20,000 to \$29,999

\_\_\_\_\_ Over \$75,000

\_\_\_\_\_ \$30,000 to \$49,999

8. How many people does this income support? \_\_\_\_\_

9. What is your employment status? I will read a list of choices. Let me know which ones apply to you.

\_\_\_\_\_ Employed full-time

\_\_\_\_\_ Disabled

\_\_\_\_\_ Employed part-time

\_\_\_\_\_ Student

\_\_\_\_\_ Retired

\_\_\_\_\_ Homemaker

\_\_\_\_\_ Unemployed

10. How do you pay for health care, for example when you go to the doctor or emergency room? This does include vision and dental check-ups. I will read the choices. Let me know which ones you usually do.

\_\_\_\_\_ I pay in full with cash or credit card.

\_\_\_\_\_ I pay in installments with cash or credit card.

\_\_\_\_\_ Private health insurance I bought for myself

\_\_\_\_\_ Private health insurance my employer provides

\_\_\_\_\_ Private health insurance my spouse's employer provides

\_\_\_\_\_ Medicaid

\_\_\_\_\_ Medicare

\_\_\_\_\_ Veterans' Administration benefits

\_\_\_\_\_ Other: \_\_\_\_\_

11. Do you have access to the Internet? \_\_\_\_\_ Yes \_\_\_\_\_ No

## **Part 5. Emergency Preparedness**

**1. Does your household have working...**

smoke detectors?  carbon monoxide detectors?  fire extinguishers?

**2. Does your household have a Family Emergency Plan?**  yes  no

**3. Does your family have a basic emergency supply kit?**

3 days worth  1 week  2 weeks  more than 2weeks

**4. Do you know what fire district you live in?**  yes  no

**That's the end! Thank you very much for completing the Community Needs Survey.**