

# **LONG ISLAND COMMUNITY HEALTH ASSESSMENT SURVEY**

*Your opinion is important to us!*

The purpose of this survey is to get your opinion about health issues that are important in your community. Together, the County Departments of Health and hospitals throughout Long Island will use the results of this survey and other information to help target health programs in your community. Please complete only one survey per adult 18 years or older. Your survey responses are anonymous. Thank you for your participation.

## **1. What are the biggest ongoing health concerns in THE COMMUNITY WHERE YOU LIVE? (Please check up to 3)**

- |                                                  |                                                                          |                                                       |
|--------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Asthma/lung disease     | <input type="checkbox"/> Heart disease & stroke                          | <input type="checkbox"/> Safety                       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> HIV/AIDS & Sexually Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | <input type="checkbox"/> Mental health                                   | <input type="checkbox"/> Women's health & wellness    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> depression/suicide                              | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drugs & alcohol abuse   |                                                                          |                                                       |
| <input type="checkbox"/> Environmental hazards   | <input type="checkbox"/> Obesity/weight loss issues                      |                                                       |

## **2. What are the biggest ongoing health concerns for YOURSELF? (Please check up to 3)**

- |                                                  |                                                                          |                                                       |
|--------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Asthma/lung disease     | <input type="checkbox"/> Heart disease & stroke                          | <input type="checkbox"/> Safety                       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> HIV/AIDS & Sexually Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccine preventable diseases |
| <input type="checkbox"/> Child health & wellness | <input type="checkbox"/> Mental health                                   | <input type="checkbox"/> Women's health & wellness    |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> depression/suicide                              | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drugs & alcohol abuse   |                                                                          |                                                       |
| <input type="checkbox"/> Environmental hazards   | <input type="checkbox"/> Obesity/weight loss issues                      |                                                       |

## **3. What prevents people in your community from getting medical treatment? (Please check up to 3)**

- |                                                                               |                                                          |                                                            |
|-------------------------------------------------------------------------------|----------------------------------------------------------|------------------------------------------------------------|
| <input type="checkbox"/> Cultural/religious beliefs                           | <input type="checkbox"/> Lack of availability of doctors | <input type="checkbox"/> Unable to pay co-pays/deductibles |
| <input type="checkbox"/> Don't know how to find doctors                       | <input type="checkbox"/> Language barriers               | <input type="checkbox"/> There are no barriers             |
| <input type="checkbox"/> Don't understand need to see a doctor                | <input type="checkbox"/> No insurance                    | <input type="checkbox"/> Other (please specify) _____      |
|                                                                               | <input type="checkbox"/> Transportation                  |                                                            |
| <input type="checkbox"/> Fear (e.g. not ready to face/discuss health problem) |                                                          |                                                            |

## **4. Which of the following is MOST needed to improve the health of your community? (Please check up to 3)**

- |                                                                 |                                                   |                                                       |
|-----------------------------------------------------------------|---------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Clean air & water                      | <input type="checkbox"/> Mental health services   | <input type="checkbox"/> Smoking cessation programs   |
| <input type="checkbox"/> Drug & alcohol rehabilitation services | <input type="checkbox"/> Recreation facilities    | <input type="checkbox"/> Transportation               |
| <input type="checkbox"/> Healthier food choices                 | <input type="checkbox"/> Safe childcare options   | <input type="checkbox"/> Weight loss programs         |
| <input type="checkbox"/> Job opportunities                      | <input type="checkbox"/> Safe places to walk/play | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Safe worksites                         |                                                   |                                                       |

## **5. What health screenings or education/information services are needed in your community? (Please check up to 3)**

- |                                                       |                                                                          |                                                       |
|-------------------------------------------------------|--------------------------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> Blood pressure               | <input type="checkbox"/> Eating disorders                                | <input type="checkbox"/> Mental health/depression     |
| <input type="checkbox"/> Cancer                       | <input type="checkbox"/> Emergency preparedness                          | <input type="checkbox"/> Nutrition                    |
| <input type="checkbox"/> Cholesterol                  | <input type="checkbox"/> Exercise/physical activity                      | <input type="checkbox"/> Prenatal care                |
| <input type="checkbox"/> Dental screenings            | <input type="checkbox"/> Heart disease                                   | <input type="checkbox"/> Suicide prevention           |
| <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> HIV/AIDS & Sexually Transmitted Diseases (STDs) | <input type="checkbox"/> Vaccination/immunizations    |
| <input type="checkbox"/> Disease outbreak information | <input type="checkbox"/> Importance of routine well checkups             | <input type="checkbox"/> Other (please specify) _____ |
| <input type="checkbox"/> Drug and alcohol             |                                                                          |                                                       |

**6. Where do you and your family get most of your health information? (Check all that apply)**

- |                                                     |                                                 |                                                                 |
|-----------------------------------------------------|-------------------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Doctor/health professional | <input type="checkbox"/> Library                | <input type="checkbox"/> Social Media (Facebook, Twitter, etc.) |
| <input type="checkbox"/> Family or friends          | <input type="checkbox"/> Newspaper/magazines    | <input type="checkbox"/> Television                             |
| <input type="checkbox"/> Health Department          | <input type="checkbox"/> Radio                  | <input type="checkbox"/> Worksite                               |
| <input type="checkbox"/> Hospital                   | <input type="checkbox"/> Religious organization | <input type="checkbox"/> Other (please specify)                 |
| <input type="checkbox"/> Internet                   | <input type="checkbox"/> School/college         | _____                                                           |

*For statistical purposes only, please complete the following:*

**I identify as:**  Male  Female  Other

**What is your age?** \_\_\_\_\_

**ZIP code where you live:** \_\_\_\_\_ **Town where you live:** \_\_\_\_\_

**What race do you consider yourself?**

- |                                                 |                                                 |                                                 |
|-------------------------------------------------|-------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> White/Caucasian        | <input type="checkbox"/> Native American        | <input type="checkbox"/> Multi-racial           |
| <input type="checkbox"/> Black/African American | <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Other (please specify) |
- \_\_\_\_\_

**Are you Hispanic or Latino?**  Yes  No

**What language do you speak when you are at home (select all that apply)**

- |                                  |                                     |                                  |                                         |                                        |                                 |
|----------------------------------|-------------------------------------|----------------------------------|-----------------------------------------|----------------------------------------|---------------------------------|
| <input type="checkbox"/> English | <input type="checkbox"/> Portuguese | <input type="checkbox"/> Spanish | <input type="checkbox"/> Italian        | <input type="checkbox"/> Farsi         | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean     | <input type="checkbox"/> Hindi   | <input type="checkbox"/> Haitian Creole | <input type="checkbox"/> French Creole | <input type="checkbox"/> Other  |

**What is your annual household income from all sources?**

- |                                               |                                                |                                               |
|-----------------------------------------------|------------------------------------------------|-----------------------------------------------|
| <input type="checkbox"/> \$0-\$19,999         | <input type="checkbox"/> \$20,000 to \$34,999  | <input type="checkbox"/> \$35,000 to \$49,999 |
| <input type="checkbox"/> \$50,000 to \$74,999 | <input type="checkbox"/> \$75,000 to \$125,000 | <input type="checkbox"/> Over \$125,000       |

**What is your highest level of education?**

- |                                               |                                           |                                                 |
|-----------------------------------------------|-------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> K-8 grade            | <input type="checkbox"/> Technical school | <input type="checkbox"/> Graduate school        |
| <input type="checkbox"/> Some high school     | <input type="checkbox"/> Some college     | <input type="checkbox"/> Doctorate              |
| <input type="checkbox"/> High school graduate | <input type="checkbox"/> College graduate | <input type="checkbox"/> Other (please specify) |
- \_\_\_\_\_

**What is your current employment status?**

- |                                             |                                        |                                                                 |
|---------------------------------------------|----------------------------------------|-----------------------------------------------------------------|
| <input type="checkbox"/> Employed for wages | <input type="checkbox"/> Self-employed | <input type="checkbox"/> Out of work and looking for work       |
| <input type="checkbox"/> Student            | <input type="checkbox"/> Retired       | <input type="checkbox"/> Out of work, but not currently looking |
| <input type="checkbox"/> Military           |                                        |                                                                 |

**Do you currently have health insurance?**  Yes  No  No, but I did in the past

**Do you have a smart phone?**  Yes  No

If you have health concerns or difficulty accessing care, please call the Long Island Health Collaborative for available resources at: <b>631-257-6957.</b>	Please return this completed survey to: LIHC Nassau-Suffolk Hospital Council 1383 Veterans Memorial Highway, Suite 26 Hauppauge, NY 11788 Or you may fax completed survey to 631-435-2343	All non-profit hospitals on Long Island offer financial assistance for emergency and medically necessary care to individuals who are unable to pay for all or a portion of their care. To obtain information on financial assistance offered at each Long Island hospital, please visit the individual hospital's website.
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