

Burlington County Office on Aging 2025 Needs Assessment Survey

<u>My Living Arrangements:</u> <input type="checkbox"/> I own my home <input type="checkbox"/> I rent my home <input type="checkbox"/> I live alone <input type="checkbox"/> or live with others	<u>My Age Group:</u> <input type="checkbox"/> 60-69 <input type="checkbox"/> 70-79 <input type="checkbox"/> 80-89 <input type="checkbox"/> 90 and older	<u>Sex:</u> <input type="checkbox"/> Male <input type="checkbox"/> Female
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Veterans Status: yes no Spouse of veteran

Transportation: (check all that apply)

I use public transportation I drive myself

Rely on friends/relatives

I use taxi or ride share services I have no access to transportation

Other (please describe) _____

I. TOP 3 CONCERNS OF BURLINGTON COUNTY SENIORS

✓ Check the top three issues or concerns that have the greatest impact on the ability of a county senior to live independently in the community: **Please check only three (3):**

<input type="checkbox"/> Chronic Health Issues	<input type="checkbox"/> Chore and Home Maintenance Services
<input type="checkbox"/> Depression/Grief/Anxiety	<input type="checkbox"/> Driving/Loss of Independence
<input type="checkbox"/> Isolation and Loneliness	<input type="checkbox"/> Organizing and Paying Bills
<input type="checkbox"/> Getting to Doctor Appointments	<input type="checkbox"/> Preparing Meals
<input type="checkbox"/> Taking Medication as Prescribed	<input type="checkbox"/> Grocery Shopping
<input type="checkbox"/> Caring for a Loved One (Caregiving)	<input type="checkbox"/> Loss of Spouse/Loved One(s)
<input type="checkbox"/> Lack of Socialization/Recreational Opportunities	<input type="checkbox"/> Memory Loss
<input type="checkbox"/> Understanding Medicare and/or Medicaid	<input type="checkbox"/> Housing Options
<input type="checkbox"/> Not Knowing Where to Go for Help	<input type="checkbox"/> In-Home Assistance with bathing, dressing
<input type="checkbox"/> Having Enough Money to meet Basic	<input type="checkbox"/> Falling (loss of balance)
<input type="checkbox"/> Life Needs (food, housing, healthcare, etc.)	<input type="checkbox"/> Other _____

II. TOP 3 SERVICES BURLINGTON COUNTY SENIORS NEED

✓ Please identify the top three services Burlington County should prioritize: Please check only three (3): **Please check only three (3):**

<input type="checkbox"/> Information on Available Services	<input type="checkbox"/> Caregiver Support & Respite
<input type="checkbox"/> Medicare/Health Insurance Counseling	<input type="checkbox"/> Alzheimer's/Dementia Education
<input type="checkbox"/> Assistance applying for programs/services	<input type="checkbox"/> Development & Coordination of Volunteer Programs to help Seniors (shopping, transportation, visitors, etc)
<input type="checkbox"/> Transportation	<input type="checkbox"/> Legal Assistance
<input type="checkbox"/> Home Delivered Meals	<input type="checkbox"/> Home Repairs and Maintenance
<input type="checkbox"/> Personal and In-Home Care Services	<input type="checkbox"/> Nutrition Counseling Education
<input type="checkbox"/> Personal Emergency Response Call System	<input type="checkbox"/> Emergency Financial Assistance
<input type="checkbox"/> Grief Counseling & Support	<input type="checkbox"/> Counseling on Long Term Care Options
<input type="checkbox"/> Health and Wellness Screenings	<input type="checkbox"/> Health Promotion Programs - Education
<input type="checkbox"/> Health Activity Programs – Exercise Classes	<input type="checkbox"/> Other _____
<input type="checkbox"/> Help with Household Chores	

Do you have any questions, concerns or comments regarding programs and services available to older adults and /or caregivers of older adults? If so, please explain below:

Are there any programs and services that you would like Burlington County Office on Aging to offer that are currently not available? If so, please explain below:

In your opinion, what are the major needs of older adults and/or Caregivers in Burlington County?

If you would like further information, please fill out the following and a Senior Services representative will follow-up with you:

Name:

Address:

Telephone Number:

Date of Birth:

E-mail:

Please list the information that you require, for example: SHIP Counselor about Medicare, Housing, Meals on Wheels, Financial Assistance, Transportation, etc.:

Thank you very much for your time and contributions to our needs assessment section of our 2025 Area Plan Contract; this is a very important part of our information gathering process.