17th ACL National Survey of Older Americans Act Participants
Caregiver Questionnaire

This is the U.S. Department of Health and Human Services' Administration for Community Living (ACL) National Survey of Older Americans Act Participants (NSOAAP) for people receiving services from the National Family Caregiver Support Program (NFCSP). More information about NSOAAP can be found at www.AoAsurvey.org.

This survey helps ACL know if the Older Americans Act (OAA) caregiver support services that you and others have received have been helpful. This survey is also conducted to better understand the needs of the individuals who use services provided through Area Agencies on Aging with funding from the NFCSP.

This survey will take about 30 minutes to complete. Your participation is voluntary and very important to the success of this study. Reports and studies resulting from this survey will summarize information provided by participants and will not associate responses with a specific individual. Your eligibility for services will not be affected by your decision to participate or by any answers you give.

It is very important that the questions in this booklet be answered by the person addressed in the letter. That person may receive assistance filling out the questionnaire, if needed, but the questions should be answered from his or her point of view.

You may skip any question that you do not want to answer, but we would really appreciate your answering all the questions you can.

MAILING INSTRUCTIONS: Please return your completed questionnaire in the pre-addressed postage paid envelope. If you have any questions about the questionnaire, please feel free to call us at 1-855-519-7052.

An agency may not conduct or sponsor, and a person is not required to respond to a collection of information, unless it displays a currently valid OMB control number. The OMB control number for this information collection is 0985-0023 and the expiration date is 5/31/24. Public reporting burden for this information collection is estimated to average 30 minutes per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to the Administration for Community Living, Washington, DC 20201 Attn: Dr. Kristen Robinson, (888) 204-0271.

A. Caregiver Support Services

A1. What is your relationship to your care receiver? You are your care receiver's...
a. Husband
b. Wife
c. Partner
d. Son or Step-son
e. Son-in-law
f. Daughter or Step-daughter
g. Daughter-in-law
h. Father
i. Mother
j. Mother-in-law
k. Brother
l. Sister
m. Sister-in-law
n. Granddaughter
o. Grandson
p. Niece
q. Nephew
r. A friend or a neighbor or another person
s. Other ___________________________

A2. Do you help your care receiver with…?

Please mark Yes or No for each item.
a. Activities like dressing, eating, bathing, or getting to the bathroom
b. Medical needs such as taking medicine or changing bandages
c. Keeping track of bills, checks, or other financial matters
d. Preparing meals, doing laundry, or cleaning the house
e. Local trips, such as going shopping or to the doctor's office
f. Arranging for care or services provided by others

A3. Did you mark "Yes" to any of the activities above (items a-f)?
a. Yes (go to A4)
b. No

If you marked No:
THANK YOU. The focus of this survey is on informal caregivers who are currently providing care to a family member or loved one. If you are not currently a caregiver for another adult person aged 60 years or older, **please stop here and go to mailing information on page 19.** Thank you for your interest in participating.

The next few questions are about caregiving experiences.

A4. What prompted you to contact the Area Agency for Aging?
a. Medical or health issue or hospitalization
b. Spouse, son/daughter, sibling, friend no longer able to help
c. Paid caregiver quit
d. Recently moved to the area

e. Need transportation
f. Just wanted information
g. Waiting list
h. Information and assistance (I&A)
i. Don't remember

A5. How long have you been receiving caregiver support services?

a. 6 months or less
b. More than 6 months, but less than 1 year
c. At least 1 year, but less than 2 years
d. 2 to 5 years
e. 5 to 10 years
f. 11 to 20 years
g. More than 20 years
h. Never received caregiver support

If you marked "Never received caregiver support":
THANK YOU. The focus of this survey is on informal caregivers who are currently providing care to a family member or loved one and receiving services from the National Family Caregiver Support Program provided through an Area Agency on Aging. If you have not received any caregiver support from this program, **please stop here and go to mailing information on page 19.** Thank you for your interest in participating.

A6. If your care receiver needed a greater amount of care, would you be able to increase your caregiving responsibilities?

a. Yes
b. No

A7. Do you know where to go to ask for respite care? *Respite care allows you a brief period of rest or relief while temporary care is provided to your care receiver in your home or your care receiver's home or someplace else.*

a. Yes
b. No

A8. Have you attended caregiver education or training such as classroom or on-line courses?

a. Yes (go to A10)
b. No

A9. Do you have a need for caregiver education or training, such as classroom or on-line courses?

a. Yes
b. No

A10. Have you attended counseling to assist with your specific caregiving situation?

a. Yes (go to A12)
b. No

A11. Do you have a need for counseling to assist with your specific caregiving situation?

a. Yes
b. No

A12. Have you attended caregiver support groups?
a. Yes (go to A14)
b. No

A13. Do you have a need for attending caregiver support groups?
a. Yes
b. No

A14. In the last year, have you needed assistance with applying or accessing other programs or services for your care receiver or yourself?
a. Yes
b. No

A15. Have the family caregiver services provided supplemental services such as…?

Please mark Yes or No for each item.
a. Home modifications, such as a ramp or grab bar
b. Liquid nutritional supplements, such as Ensure, Boost, or Glucerna
c. Walkers, canes, crutches, Hoyer Lift, microwaves
d. Emergency response systems, CPAP or apnea machines, hospital bed, a device to monitor wandering
e. Consumable supplies such as wound care, catheter, or incontinence supplies *(Consumable supplies are things that you use once and throw away.)*
f. Money or stipend

A16. As a result of the caregiver services you have received, do you…?

Please mark Yes or No for each item.
a. Have more time for personal activities
b. Feel less stress
c. Find it easier to care for your care receiver
d. Have a clearer understanding of how to get the services you and your care receiver need
e. Know more about your care receiver's condition or illness

A17. Have these caregiver services helped you to be a better caregiver?
a. Yes
b. No

A18. Have these caregiver services enabled you to provide care for your care receiver for a longer time than would have been possible without these services?
a. Yes
b. No

A19. Overall, how would you rate the caregiver support services you received?
a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

A20. Has it been difficult for you to get services from agencies for your care receiver?
a. Yes
b. No

B. Caregiving and Employment/Expenses

The next few questions are about your employment.

B1. Are you currently employed?
a. Yes
b. No (go to B5)

B2. Has providing care for your care receiver interfered with your job?
a. Yes
b. No (go to B5)

B3. Because of providing care for your care receiver, did you…?

Please mark Yes or No for each item.
a. Take a less demanding job
b. Change from full-time to part-time work or reduce your official working hours
c. Lose some of your employment fringe benefits
d. Have time conflicts between working and caregiving
e. Use your vacation time to provide care
f. Take a leave of absence to provide care
g. Lose a promotion
h. Work less than your normal number of hours last month

B4. Did the caregiver support services help you deal with these work difficulties?
a. Yes
b. No

B5. As a result of caregiving-related changes in your employment or expenses, have you had to…?

Please mark Yes or No for each item.
a. Dip into your savings
b. Cut back on your own spending for vacations or travel, entertainment, going out, or other leisure activities
c. Cut down on your own spending for groceries or meals
d. Cut back on your own spending on health care, dental care, or prescription medicine
e. Cut back on your own spending for household expenses and maintenance
f. Quit your job

The following questions are about your situation as a caregiver.

B6. How much satisfaction do you gain from performing your care tasks?
a. No satisfaction
b. Some satisfaction
c. A lot of satisfaction

B7. In the last year, have you used your own money to pay for your care receiver's…?

Please mark Yes or No for each item.
a. Medications or medical care
b. Insurance premiums or copayments
c. Mobility devices, such as walkers, canes, or wheelchairs
d. Features that have made your care receiver's home safer, such as a railing or ramp, grab bars in the bathroom, a seat for the shower or tub or an emergency response system
e. Any other assistive devices that make it easier or safer to do activities or allow your care receiver to do them on their own

C. Well-Being, Social Integration, and Health

The following questions are about how <u>you</u> feel these days.

C1a. How much of the time during the past four weeks have you felt calm and peaceful?
a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

C1b. How much of the time during the past four weeks have you had a lot of energy?
a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

C1c. How much of the time during the past four weeks have you felt downhearted or depressed?
a. All of the time
b. Most of the time
c. Some of the time
d. A little of the time
e. None of the time

C2. Regarding your present social activities, do you feel that you are doing…
a. About enough
b. Too much
c. Would like to be doing more

C3. Have your social opportunities increased since you became involved with your Area Agency on Aging (AAA)?

a. Yes
b. No

C4. How often does…..?

Please mark one of the following options for each item: Always, Usually, Sometimes, Rarely, or Never

a. Caregiving prevent you from having enough time for yourself
b. Caregiving prevent you from having enough time for your family
c. Caregiving conflict with your social life
d. Being a caregiver for your care receiver give you the joy of spending time with someone you care about
e. Being a caregiver provide you with a sense of accomplishment

C5. How often do you feel that your care receiver appreciates the care that you are providing?

a. Always
b. Usually
c. Sometimes
d. Rarely
e. Never

C6. As a caregiver, how often do you feel you are fulfilling your duty by caring for your care receiver?

a. Always
b. Usually
c. Sometimes
d. Rarely
e. Never

C7. For the next set of questions, please respond to how true the statement is for you.

Please mark one of the following options for each item: Not at all true, Hardly true, Moderately true, or Exactly true

a. You are confident that you could deal efficiently with unexpected events.
b. You can remain calm when facing difficulties because you can rely on your coping abilities.
c. You can usually handle whatever comes your way.

The next set of questions is about your health.

C8. Compared to one year ago, how would you rate your health in general now?

a. Much better
b. Somewhat better
c. About the same
d. Somewhat worse
e. Much worse

C9. In the past month, have you been bothered by pain?
a. Yes
b. No (go to C11)

C10. In the last month, how often has pain limited your activities?
a. Every day
b. Most days
c. Some days
d. Rarely
e. Never

C11. In the past 12 months, have you been to see a doctor or gone to an urgent care center? *Do not include going to the hospital emergency department. Doctor includes Physician Assistant or Nurse Practitioner.*
a. Yes
b. No

C12. In the past 12 months, have you ever missed or delayed routine doctor visits because of your caregiving situation?
a. Yes
b. No

C13. In the past 12 months, have you been to a hospital emergency department?
a. Yes
b. No (go to C15)

C14. In the past 12 months, how many times did you go to a hospital emergency department?
____________Number of times at hospital emergency department

C15. In the past 12 months, did you have to stay overnight in a hospital?
a. Yes
b. No (go to D1)

C16. In the past 12 months, how many times were you hospitalized for one night or longer?
___________ Number of times hospitalized overnight

D. Caregiving Situation

D1. Thinking about all the family members or friends who provide help, care, or supervision for your care receiver, what proportion of the care do <u>you</u> provide during a typical week?
a. Less than one-quarter
b. About one-quarter
c. About one-half
d. About three-quarters
e. All or almost all of the care

The next set of questions ask about any thoughts you have had about alternative types of care.

D2. In the past 6 months, have you ever considered a nursing home, boarding home, or assisted living for your care receiver?
a. Yes
b. No

D3. In the past 6 months, have you felt that your care receiver would be better off in a nursing home, boarding home, or assisted living facility?
a. Yes
b. No (go to D6)

D4. In the past 6 months, have you discussed that possibility with your care receiver?
a. Yes
b. No (go to D6)

D5. In the past 6 months, have you taken any steps toward placement?
a. Yes
b. No

D6. Are you responsible for providing help or supervision to your care receiver on a 24-hour basis?
a. Yes
b. No (go to D8)

D7. On a scale from 1 to 5 where 1 is not very intense and 5 is very intense, how intense is the care you provide? ______________

D8. Would you recommend the caregiving support services to a friend?
a. Yes
b. No

D9. Do you have any recommendations to improve the caregiver support services?
a. Yes
b. No (go to D11)

D10. What main recommendation do you have for improving caregiver support services you have received?

Mark only one.
a. Information about available services
b. Assistance gaining access to services
c. Caregiver education/training, individual counseling, and support groups
d. Respite care
e. Other supplemental services
f. Something else

D11. Overall, do you feel like you have enough support?
a. Yes
b. No

E. Nutrition

E1. In the past 12 months, have you tried to get meals, food, or groceries through your Area Agency on Aging (AAA)?

a. Yes
b. No (go to E2)

E1a. Were you unable to get food?

a. Yes
b. No (go to E2)

E1b. Were you unable to get meals, food, or groceries from your Area Agency on Aging for any of the following reasons?

Mark all that apply.

a. No response from AAA
b. I was put on a waiting list
c. I was told that I could not have more meals or food
d. I was told there was no more food available
e. I was told there was not enough staff
f. I was unable to pick up the meals or get to the meal pick-up place

E2. Have you recently lost weight without trying? If you are unsure, some things that might indicate weight loss are clothes or rings fitting looser, or using a different belt notch.

a. Yes
b. No (go to E3)

E2a. How much weight have you lost?

a. 2-13 lbs
b. 14-23 lbs
c. 24-33 lbs
d. 34 lbs or more
e. Unsure

E3. Have you been eating poorly because of a decreased appetite? For example, eating less than 75% of your usual intake. Most often this is due to poor appetite, but there may be other reasons sometimes such as chewing or swallowing difficulties.

a. Yes
b. No

E4. Have you recently gained weight without trying?

a. Yes
b. No (go to E5)
c. Unsure (go to E5)

E4a. How much weight have you gained?

_______ Number of pounds

Below are several statements that people have made about their food situation. They use the terms "we" and "your household". A household includes everyone who lives with you. If you live alone, then you are a household of one.

E5. "The food that we bought just didn't last, and we didn't have money to get more." Was that often, sometimes, or never true for your household in the last 12 months?

a. Often true
b. Sometimes true
c. Never true

E6. "We couldn't afford to eat balanced meals." Was that often, sometimes, or never true for your household in the last 12 months?

a. Often true
b. Sometimes true
c. Never true

E7. In the last 12 months, did you or other adults in your household ever cut the size of your meals or skip meals because there wasn't enough money for food?

a. Yes
b. No (go to E8)

E7a. How often did this happen?

a. Almost every month
b. Some months but not every month
c. Only 1 or 2 months

E8. In the last 12 months, did you ever eat less than you felt you should because there wasn't enough money for food?

a. Yes
b. No

E9. In the last 12 months, were you ever hungry but didn't eat because there wasn't enough money for food?

a. Yes
b. No

F. Care Receiver Additional Services

F1. These next questions ask about additional help your care receiver (CR) may have received from your Area Agency on Aging (AAA).

Please mark Yes or No for each item.

a. In the past year, has your CR attended a meals program at a senior center or other group setting?
b. In the past year, has your CR received meals or other food from the meals program?
c. In the past year, has your CR received Homemaker or Housekeeping services? (*These are services that may include help with doing light housework, laundry, preparing meals, shopping, or delivery of groceries or prescriptions*.)

d. In the past year, has your CR received case management services? (*When someone receives case management, they have a case manager who may set up in-home services, such as homemaker or personal care services for them. The case manager may also call to check on how they are doing, or how they like the services.)*
e. In the past year, has your CR received transportation services?
f. In the past year, has your CR received adult daycare services? (*Adult Day Care or adult health is when people go to a place to spend the day.)*
g. In the past year, has your CR received personal care services? (*Personal care services are help with care like dressing or bathing.)*
h. In the past year, has your CR received heavy chore services, such as washing windows, yardwork, or shoveling snow? (*Chore Services help with heavier housecleaning and yard work.)*
i. In the past year, has your CR received legal assistance? (*Legal Assistance may help with making a will or understanding a bill and other legal matter.)*
j. In the past year, has your CR received information and assistance services? (*Information and Assistance helps people find out about services that are available to them.)*
k. Has your CR received flu shots, pneumonia shots, COVID vaccinations, or other immunizations from your AAA?
l. Has your CR received assistance in administering or monitoring the side effects of medicine from your AAA?

F2. Did you mark "Yes" to any of the additional services in the table above (items a-l)?
a. Yes
b. No (go to F4)

F3. Overall, how would you rate the **group** of services the person you care for receives?
a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

F4. Is the person you care for receiving any other types of assistance, such as…

Please mark Yes or No for each item.
a. Food stamps?
b. Energy Assistance?
c. Medicaid?
d. Housing Assistance?

F5. Does your care receiver's family or friends help arrange for the services your care receiver receives?
a. Yes
b. No

G. Falls

The next few questions are about falling down (any fall, slip, or trip in which you lose your balance and land on the floor or ground or at a lower level.)

G1. In the last month, have you fallen down?
  a. Yes
  b. No

G2. In the last month, did you worry about falling down?
  a. Yes
  b. No (go to H1)

G3. In the last month, did this worry ever limit your activities?
  a. Yes
  b. No

H. Social Integration

The next few questions are about your contact with other people.

H1. How often do you feel that you lack companionship?
  a. Hardly ever
  b. Some of the time
  c. Often

H2. How often do you feel left out?
  a. Hardly ever
  b. Some of the time
  c. Often

H3. How often do you feel isolated from others?
  a. Hardly ever
  b. Some of the time
  c. Often

H4. How often do you feel alone?
  a. Never
  b. Hardly ever
  c. Some of the time
  d. Often

I. Care Receiver Health Status and Medical Conditions

I1. In your judgment, if the services that you and your care receiver have received had not been available, would your care receiver be able to continue to live in the same residence?

a. Yes (go to I3)
b. No

I2. Where would your care receiver be living? Mark only one.

a. In caregiver's home
b. In the home of another family member or friend
c. In an assisted living facility
d. In a nursing home
e. Care receiver would have died
f. Other

The next few questions are about the health of your care receiver.

I3. In general, how is your care receiver's health?

a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

I4. Has a doctor ever said that your care receiver has….?

Please mark Yes or No for each item.

a. Arthritis or rheumatism
b. High blood pressure or hypertension
c. A heart attack, coronary heart disease, angina, congestive heart failure, or other heart problems
d. High cholesterol
e. Diabetes or high blood sugar
f. Allergies/asthma/emphysema/chronic bronchitis/other breathing or lung problems
g. Cancer or a malignant tumor, excluding minor skin cancer
h. Stroke
i. Anemia (*such as iron-deficiency*)
j. Osteoporosis
k. Kidney disease
l. Eye or vision conditions such as glaucoma, cataracts, macular degeneration or other medical conditions (*This does not include needing to wear glasses or contact lenses.*)
m. Hearing problems
n. An emotional or mental health condition
o. Memory related disease such as Alzheimer's or dementia
p. Seizures or epilepsy
q. Parkinson's disease
r. Multiple Sclerosis
s. A serious problem with urinary incontinence
t. Thyroid disease
u. A digestive or colon-related condition
v. Human immunodeficiency virus (HIV)

I15. Does your care receiver have access to public transportation such as a bus or rail?
a. Yes
b. No

Now we would like to ask about oral or dental health, that is, the health of your care receiver's teeth and gums.

I16. About how long has it been since your care receiver last visited a dentist? Include dental hygienists, orthodontists, oral surgeons, and other dental-related specialists.
a. 6 months or less
b. More than 6 months, but not more than 1 year ago
c. More than 1 year, but not more than 2 years ago
d. More than 2 years, but not more than 3 years ago
e. More than 3 years, but not more than 5 years ago
f. More than 5 years ago
g. Never has been to a dentist
h. Not applicable – has dentures

I17. During the past 12 months, was there a time when your care receiver needed dental care but could not get it at that time?
a. Yes
b. No

I18. Overall, how would you rate the health of your care receiver's teeth and gums?
a. Excellent
b. Very good
c. Good
d. Fair
e. Poor

J. Care Receiver's Activities and Instrumental Activities of Daily Living (ADL/IADLs)

The next set of questions ask about your care receiver's ability to perform some common activities of everyday life and whether your care receiver needs assistance performing these activities. We are only interested in long-term conditions, not temporary conditions.

J1. Does your care receiver have difficulty…..

Please mark Yes or No for each item.
a. getting in or out of bed or a chair?
b. when taking a bath or shower?
c. when dressing?
d. when walking or getting around inside the home?
e. eating?
f. using the toilet?
g. going outside the home, for example to shop or visit a doctor's office?
h. keeping track of money or bills?

i. preparing meals?
j. doing light housework, such as washing dishes or sweeping a floor?
k. doing heavy housework, such as scrubbing floors or washing windows?
l. taking the right amount of prescribed medicine at the right time?
m. using the phone?

J2. Is there a car or personal motor vehicle in working condition in your care receiver's household?
a. Yes
b. No

J3. Does your care receiver have difficulty driving a car or other personal motor vehicle?
a. Yes
b. No
c. Not applicable (because CR does not want or need to drive)
d. Not applicable (because household does not have a working vehicle)

J4. Does your care receiver have difficulty using public transportation such as a bus or rail?
a. Yes
b. No
c. Never uses public transportation

J5. What is your care receiver's current age?
__________ Age

K. Other Persons Caregiver Supports

K1. How many persons total are you caring for not counting this care receiver?
_____________ Number of people

If none, enter 0.
If you answered 0, go to L1.

K2. Not counting your care receiver, how are the other people you care for related to you? Mark all that apply.
a. Husband, wife, or partner
b. Son(s) or daughter(s)
c. Father
d. Mother
e. Friend(s) or neighbor(s)
f. Cousin or other relative(s)
g. Grandson(s) or granddaughter(s)
h. Brother(s) or sister(s)
i. Brother-in-law or sister-in-law
j. Other persons not mentioned above

L. Demographics

The purpose of the following questions is to help ACL and its network of AAAs better understand the level of satisfaction and needs of all clients based on several types of demographic information. The goal is to provide equitable community-based programs and support services to all clients. Only ACL's contracted research team will have access to this information. Your responses will be kept confidential and secure. Any reports and studies resulting from this survey will summarize information and not identify any individuals. The information will not be used for any discriminatory purpose.

L1. What is your age? __________

L2. What is your highest level of education?

a. Less than high school diploma
b. High school diploma or GED
c. Some college, including Associate's degree (includes business school and vocational or technical school)
d. Bachelor's degree
e. Some post-graduate work or advanced degree

L3. Are you Hispanic or Latino?

a. Yes
b. No

H4. Which one or more of the following best describes your race? Mark all that apply.

a. White
b. Black or African American
c. Asian
d. American Indian or Alaska Native
e. Native Hawaiian or other Pacific
f. Islander
g. Some other race (specify) _________________

L5. Have you ever served on active duty in the U.S. Armed Forces, military Reserves or National Guard? Active duty does not include training for the Reserves or National Guard.

a. Yes
b. No

L6. Is your home located in…

a. The city
b. The suburbs
c. A rural area
d. Don't know

L7. What is your current marital status?

a. Married
b. Living with a partner
c. Widowed
d. Divorced
e. Separated
f. Never Married

L8. We'd like to ask about the persons who live in your household. Does anyone else live with you?

a. Yes
b. No (go to L9)

L8a. If yes...

Please mark Yes or No for each question.

a. Do you live with your spouse or unmarried partner?
b. Do you live in the home of one of your children?
c. Do one or more of your children live with you?
d. Do you live with other relatives?
e. Do you live with non-relatives?

L8b. Including yourself, how many people live in your household?
________ Number of household members

L9. What sex were you assigned at birth, on your original birth certificate?

a. Female
b. Male
c. Prefer not to answer

L10. What is your current gender? Mark only one.

a. Female
b. Male
c. Transgender
d. Two-Spirit (American Indian or Alaska Native)
e. I use a different term (specify: ____________________)
f. Prefer not to answer

L11. Which of the following best represents how you think of yourself? Mark only one.

a. Lesbian or gay
b. Straight, that is, not lesbian or gay
c. Bisexual
d. Two-Spirit (American Indian or Alaska Native)
e. I use a different term (specify: ___________________)
f. Prefer not to answer

L12. Thinking about the total combined income from all sources for all persons in your household, including income from jobs, Social Security, retirement income, public assistance, and all other sources, which category best describes your total household annual income during the year 2022?

a. $5,000 or less ($417 or less per month)
b. $5,001 - $10,000 ($418 to $833 per month)
c. $10,001 - $15,000 ($834 to $1,250 per month)
d. $15,001 - $20,000 ($1,251 to $1,666 per month)
e. $20,001 - $25,000 ($1,667 to $2,083 per month)
f. $25,001 - $30,000 ($2,084 to $2,500 per month)

g. $30,001 - $35,000 ($2,501 to $2,917 per month)
h. $35,001 - $40,000 ($2,918 to $3,333 per month)
i. $40,001 - $50,000 ($3,334 to $4,167 per month)
j. Over $50,000 ($4,168 or more per month)
k. Prefer not to answer

L13. Did someone else complete this survey for the person addressed in the letter?
a. Yes
b. No

THANK YOU!

Your answers will help us better evaluate the services funded by the Older Americans Act.

Please return your completed questionnaire in the pre-addressed postage paid envelope to:

Westat
1600 Research Blvd., Room# RCB16
Rockville, MD 20850