

# FAMILY CAREGIVER SURVEY

If you do anything to help a frail older person, **YOU** are a family caregiver. Family Caregivers provide 80% of the long-term care in this country. We would like your help in planning programs to make the lives of current and future caregivers easier. PLEASE take a few minutes and complete this survey. This survey is also available at [www.landofsky.org](http://www.landofsky.org). It may be completed and emailed to Carol McLimans at [carol@landofsky.org](mailto:carol@landofsky.org).

**We want to hear from YOU!**  
**We need to hear from YOU!**

Land of Sky Regional Council Family Caregiver Support Program

**Please take a moment to complete this survey  
and submit by email, mail or fax to**

Land of Sky Regional Council  
Family Caregiver Support Program  
339 New Leicester Hwy, Ste 140  
828-251-7439 Phone  
828-251-6353 Fax  
email [carol@landofsky.org](mailto:carol@landofsky.org)



**SECTION I ABOUT YOU ..... Page 3**

Please tell us a little about yourself whether or not you currently have caregiving responsibilities.

**SECTION II ADULT AND OLDER ADULT CAREGIVER NEEDS ..... Page 5**

Complete Section II if you provide care or assistance for someone age 60 or older or someone of any age with Alzheimer's disease.

This survey will be analyzed to develop a snapshot view of the caregiver needs within the four counties (Buncombe, Henderson, Madison and Transylvania) served by Land of Sky Regional Council.

Additional space will be available at the end of this survey for you to add any additional information you feel would be valuable in assisting you or others that care for older adults.

**All individual responses are anonymous and will be kept strictly confidential.**

Please return your completed survey by July 18, 2014 to: Family Caregiver Support Program, Land of Sky Regional Council, 339 New Leicester Hwy, Ste 140, Asheville, NC 28806 or email to [carol@landofsky.org](mailto:carol@landofsky.org) or fax to 828-251-6353. If you have any questions, please feel free to contact us at 828-251-7439 or [carol@landofsky.org](mailto:carol@landofsky.org). Thank you for your time and cooperation.

Carol McLimans,  
Family Caregiver Specialist  
Land of Sky Regional Council

## SECTION I: ABOUT YOU

1. Your gender:                    Male                    Female

2. Your age:

3. Your race/ethnicity: *(Please check one.)*

White (not of Hispanic origin)

Asian/Pacific Islander

Hispanic/Latino

American Indian/Alaskan Native

African American/Black

Other (specify)

4. Your marital status: *(Please check one.)*

Married/living with partner

Widowed or divorced

Single (never married)

5. Your total annual household income: *(Please check one.)*

Under \$25,000

\$50,001- \$100,000

\$25,000 - \$50,000

Over \$100,000

6. What city do you live in and your zip code?

7. Do you anticipate needing to care for a frail older adult in the next **two** years?

Yes

No

**PLEASE READ:** If you are caring or have cared for a frail older adult, proceed to Question 8 and tell us about the adults you care(d)for. Otherwise, go to Question 15 on page 9 of this survey.

8. Please mark below any frail older adult that you care for now or have cared for in the past?  
*(Please state the age for each person you are a care giver for.)*

Spouse/partner

Other relative

Mother or father

Friend or neighbor

Mother-in-law or father-in-law

Other (specify)

Grandparent

9. Is care recipient a Veteran?                      Yes                      No

10. What county does the person(s) you care for live in?

Buncombe County

Henderson County

Madison County

Transylvania County

11. Does the person(s) you care for live with you or in their own home?

Their home

Lives with me

12. What is their disability, diagnosis or the reason you are a care provider?

13. How comfortable are you with skills needed to care for Care Recipient? *(Please rate those that are applicable)*

	Very Comfortable	Somewhat Comfortable	Not At All Comfortable
Administering medications (e.g. injections, IV use, eye drops)			
Assisting with personal hygiene			
Recognizing signs and symptoms of pain			
Wound Care/ Ostomy Care			
Use of Incontinence equipment, e.g. catheters, enemas			
Using home oxygen, suctioning			
Assisting with physical movement when unable to do so for self, utilizing correct lifting and moving techniques			
Use of Assistive devices, e.g. walkers, wheelchairs, canes			
Use of monitors, e.g. glucometer, blood pressure monitor, telehealth equipment			
Medical Equipment, e.g. tube feeding, home dialysis			

## SECTION II. OLDER ADULT CAREGIVER NEEDS

1. How long have you been a caregiver? *(Please check one.)*

< 6 months

6 months to 1 year

1-2 years

2-5 years

>5 years

2. What kind of assistance do you provide? *(Please check all that apply.)*

Cooking, laundry or house cleaning

Home Maintenance or repair

Transportation

Feeding, bathing toileting, dressing or grooming

Assistance with transferring to chair/bed

Meal preparation

Shopping

Administering medications

Managing the person's financial affairs

Direct financial support

Providing emotional reassurance

Arranging and monitoring outside help or services

Other (specify)

3. Overall, approximately how many hours do you spend caregiving or assisting this person(s) in a typical **week**? *(Please check one.)*

< 4 hours/week

30-40 hours/week

4-19 hours/week

more than 40 hours/week

20-29 hours/week

4. Overall, how much money do you spend caregiving or assisting this person(s) in a typical **month**?  
*(Please check one.)*

- |                     |                   |
|---------------------|-------------------|
| None                | \$500-\$999/mo.   |
| Less than \$100/mo. | \$1000-\$1499/mo. |
| \$100-\$249/mo.     | \$1500+ per mo.   |
| \$250-\$499/mo.     |                   |

5. Which of these concerns have you experienced as a result of your caregiving responsibilities?  
*(Please rate each one as Very Concerned, Somewhat Concerned, or Not Concerned.)*

	Very Concerned	Somewhat Concerned	Not Concerned or N/A
Finding trained & reliable home care providers			
Having enough money to pay for care			
Understanding government programs such as Medicare, Medicaid, SSI			
Learning about legal options			
Getting cooperation & assistance from other family members			
Ensuring the care recipient's safety			
Finding transportation			
Communicating with healthcare professionals			
Talking with Care Recipient's doctor			
Planning for end of life care			
Balancing other family responsibilities			
Dealing with dangerous, unwanted, or difficult behaviors of the care recipient			
Modifying home to meet care requirements			
Meeting my personal needs such as personal time, exercise, work schedule, social activities, sleep			
Other(specify)			

6. Has caregiving caused you:

- |                               |     |    |
|-------------------------------|-----|----|
| a. Physical/Health Changes    | Yes | No |
| b. Financial strain           | Yes | No |
| c. Emotional strain or stress | Yes | No |

7. Briefly describe those strains/stresses checked yes above.

8. Describe help received from family and friends.

Receive no help

Far less help than needed

Somewhat less help than needed

About what I need

I need no help

9. Has your employment status changed because of caregiving duties? (*Check all that apply.*)

No change

Increased Hours

Quit Job

Changed Jobs

Decreased Hours

Laid Off

Family/Medical Leave

Early Retirement

Other

Paid

Unpaid

Began Working

10. Approximately how many full or partial scheduled workdays did you miss during the past 12 months due to your caregiving responsibilities? (*Please check one.*)

0 days

1-4 days

5-9 days

10 or more days

11. Which of the following resources do you currently use or would you find useful? (*Please check all that apply.*)

	Currently Use	Would Use
Workshops/seminars on adult care issues		
Workshops/seminars on taking care of myself		
Brochures, pamphlets, or other written information		
Internet references on caregiving		

	Currently Use	Would Use
Caregiver support group		
Individual counseling		
Help locating services		
Legal consultation		
Mediation services to aid in caregiver family disputes		
Personal emergency response systems such as Lifeline		
Home adaptation (wheelchair ramp, etc.)		
Medical Equipment (Please Specify):		
Assistance with Medicare, Medicaid or SSI		
Help in determining long term care options		
Help with admitting care recipient to long term care facility		
Support following the death of the care recipient		
Health promotion (e.g. diet, exercise)		
Money management services		
I would like more information about (Please Specify):		
Other: (Please list)		

12. What community and/or in home services do you currently use, have used or would you find helpful. *(Please check all that apply)*

	Currently Use	Would Use
Adult Day Care		
Adult Protective Services		
Care Management		
Chores or housekeeping		
Home Care provided by an agency		
Home Delivered Meals		
Home Repair services		
Hospice		
Sitter/companion service		
List of sitters/home aides for hire		
Transportation		
Other (specify)		



13. If any of the above were checked "Would Use", **why** do you not currently use them? (*Check any that apply*)

Not available in my area

Not convenient

Cost

Care Recipient will not allow or not interested

Unable to access because of transportation

Other:

14. Please tell us how caregiving has affected you in a **positive** way.

15. Please provide any additional comments you might have about your past, present, and anticipated caregiver needs.

**If you need information about available senior or community services, call 2-1-1. For additional information about services outside Buncombe, Henderson, Madison, and Transylvania Counties call the Elder Locator at 1-800-677-1116.**

Please use this additional space for any comments or information you would like to add that would be beneficial to us in developing programs and services for care givers.

**Thank you very much for completing this survey!**

Please return the completed form by mail, email, or fax by July 18, 2014, to

Land of Sky Regional Council

Family Caregiver Support Program

339 New Leicester Hwy, Ste 140, Asheville, NC 28806

Email [carol@landofsky.org](mailto:carol@landofsky.org)

Fax 828-251-6353

For information call Carol McLimans at 828-251-7439 or 1-800-727-0557