

AUTISM NEEDS ASSESSMENT



Please note that you must be at least 18 years of age to complete this survey

Thank you for agreeing to complete this survey. Since most respondents will be parents/guardians, we refer to the person with autism as “your child.” The term autism is used to refer to all Autism Spectrum Disorders (ASD). Please complete this survey for your oldest child with autism. Mark only one answer choice per question unless otherwise specified.

1. Please identify yourself:

- | | |
|--|---|
| <input type="checkbox"/> Mother | <input type="checkbox"/> Foster parent |
| <input type="checkbox"/> Father | <input type="checkbox"/> Legal guardian |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

2. Which of the following best describes your current marital status?

- | | |
|--|---|
| <input type="checkbox"/> Married to/Living with child’s other parent | <input type="checkbox"/> Never been married |
| <input type="checkbox"/> Married to/Living with person other than child’s parent | <input type="checkbox"/> Separated/Divorced |
| <input type="checkbox"/> Widowed | |

3. What is your race/ethnicity? (*Check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Latino, Hispanic, or Chicano |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Caucasian/European American | |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

4. What is the race/ethnicity of your spouse or significant other? (*Check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> African American | <input type="checkbox"/> Latino, Hispanic, or Chicano |
| <input type="checkbox"/> Asian/Pacific Islander | <input type="checkbox"/> Native American |
| <input type="checkbox"/> Caucasian/European American | <input type="checkbox"/> N/A |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

5. What is your zip code (e.g. 19104)?

--	--	--	--	--

6. Which of the following is closest to your annual household income?

- | | |
|--|---|
| <input type="checkbox"/> Under \$20,000 | <input type="checkbox"/> \$60,000-\$79,999 |
| <input type="checkbox"/> \$20,000-\$39,999 | <input type="checkbox"/> \$80,000-\$99,999 |
| <input type="checkbox"/> \$40,000-\$59,999 | <input type="checkbox"/> \$100,000 or above |

7. What is your highest level of completed education?

- | | |
|--|--|
| <input type="checkbox"/> No high school | <input type="checkbox"/> Some college |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College degree |
| <input type="checkbox"/> High school graduate/GED | <input type="checkbox"/> Some graduate studies |
| <input type="checkbox"/> Vocational/Technical school | <input type="checkbox"/> Graduate degree |

8. What is the sex of your child?

- Male
- Female

9. How old is your child? _____ years _____ months

10. Is your child adopted?

- Yes
- No

11. What is his/her race/ethnicity? (*Check all that apply*)

- African American
- Asian/Pacific Islander
- Caucasian/European American
- Latino/Hispanic/Chicano
- Native American
- Other (*Please specify*) _____

12. How many siblings does he/she have? _____

13. How many of those siblings have also been diagnosed with autism? _____

14. What is your child's primary diagnosis?

- Asperger's Disorder
- Autistic Disorder/Autism
- Childhood Disintegrative Disorder
- Pervasive Developmental Disorder (PDD/NOS)
- Rett Syndrome
- Other (*Please specify*) _____

15. Does your child **currently** have any of the following diagnoses? (*Check all that apply*)

- Anxiety Disorder
- Attention Deficit/Hyperactivity Disorder
- Bipolar Disorder
- Central Auditory Processing Disorder
- Conduct Disorder (CD)
- Depression
- Developmental Delays
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None
- Other (*Please specify*) _____

16. Did your child receive any of the following diagnoses **prior** to receiving his/her autism diagnosis?
(*Check all that apply*)

- Anxiety Disorder
- Attention Deficit/Hyperactivity Disorder
- Bipolar Disorder
- Central Auditory Processing Disorder
- Conduct Disorder (CD)
- Depression
- Developmental Delays
- Hearing Impairment
- Learning Disability
- Mental Retardation/ Intellectual Disability
- Obsessive Compulsive Disorder (OCD)
- Oppositional Defiant Disorder (ODD)
- Seizures/ Seizure Disorder/Epilepsy
- None
- Other (*Please specify*) _____



17. How old was your child when you first became concerned about his/her development?
 _____ years _____ months

18. What type of professional first diagnosed your child with autism?

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Developmental Pediatrician | <input type="checkbox"/> Psychiatrist |
| <input type="checkbox"/> Educational team (IEP or EI) | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Neurologist | |
| <input type="checkbox"/> Primary Care Physician (Family doctor/Pediatrician) | |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

19. About how many miles did you travel for the initial autism diagnosis (roundtrip)?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> 0-20 miles | <input type="checkbox"/> 61-80 miles |
| <input type="checkbox"/> 21-40 miles | <input type="checkbox"/> 81-100 miles |
| <input type="checkbox"/> 41-60 miles | <input type="checkbox"/> More than 100 miles |

20. How old was your child when he/she received this diagnosis? _____ years _____ months

21. How many professionals (e.g. psychologist, developmental pediatrician) did you visit before your child received an autism diagnosis? _____

22. After receiving a diagnosis, what sort of follow-up and resources/services did you receive? (*Check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Follow-up appointment | <input type="checkbox"/> Referral to support groups |
| <input type="checkbox"/> Referral to a specialist for further assessment | <input type="checkbox"/> Referral to websites, literature
(e.g. handouts, information booklets) |
| <input type="checkbox"/> Referral to a specialist for treatment | <input type="checkbox"/> None |
| <input type="checkbox"/> Referral to Early Intervention services | |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

23. How do you pay for your child's health care services? (*Check all that apply*)

- | | |
|--|--|
| <input type="checkbox"/> Private health insurance | <input type="checkbox"/> Out-of-pocket |
| <input type="checkbox"/> Medicaid (Medical Access) | <input type="checkbox"/> I don't know |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

24. In the past year, have you taken your child to the emergency room for behavioral or psychiatric reasons?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| On how many occasions? _____ | |

25. In the past year, has your child been admitted to a hospital or hospital-like setting for behavioral or psychiatric reasons?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| On how many occasions? _____ | |

If you answered "No" to question 25, please SKIP to question 26

25a. What was/were the reason(s) your child was admitted to a hospital or hospital-like setting? (*Check all that apply*)

- | | |
|--|---|
| <input type="checkbox"/> Aggression | <input type="checkbox"/> Running away from home/school |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Self-injurious behaviors |
| <input type="checkbox"/> Defiant/Oppositional behaviors | <input type="checkbox"/> Significant increase in obsessions |
| <input type="checkbox"/> Depression | |
| <input type="checkbox"/> Other (<i>Please specify</i>) _____ | |

25b-d. How satisfied or dissatisfied were you with the following aspects of your child's hospital stay?

	Very Satisfied	Satisfied	Dissatisfied	Very Dissatisfied
b. Discharge Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Staff's Inclusion of Parent(s) in Treatment Planning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Quality of Treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25e. How was your child admitted?

- My child (under 14) was admitted by his/her parent(s)
- My adolescent child (14 to 18) was admitted by his/her parent(s) and agreed to the admission
- My adolescent child (14 to 18) was admitted by his/her parent(s) but did not agree to the admission
- My adult child (18 or older) admitted him/herself (201, voluntary treatment)
- My adult child (18 or older) was admitted against his/her will (302, involuntary treatment)

Please continue answering the questions

26. In the past year, has your child been placed in a residential facility?

- | | |
|--|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No and not on a waiting list |
| <input type="checkbox"/> No, but currently on a waiting list | |

If your child has not been placed in a residential facility or is not currently on a waiting list, please SKIP to question 27

26a. About how many miles is this residential facility away from your home?

- | | |
|--------------------------------------|--|
| <input type="checkbox"/> 0-20 miles | <input type="checkbox"/> 61-80 miles |
| <input type="checkbox"/> 21-40 miles | <input type="checkbox"/> 81-100 miles |
| <input type="checkbox"/> 41-60 miles | <input type="checkbox"/> More than 100 miles |

Please continue answering the questions

27. What is your child's current living situation?

- | | |
|--|---|
| <input type="checkbox"/> With parent(s) in a family home | <input type="checkbox"/> Group home |
| <input type="checkbox"/> With other relative(s) in a family home | <input type="checkbox"/> Lives on own with support |
| <input type="checkbox"/> Residential facility | <input type="checkbox"/> Lives on own without support |

33. In what ways (if any) has your child's autism affected your family's workforce participation? *(Check all that apply)*

	Me	My Partner
a. Stopped working outside the home	<input type="checkbox"/>	<input type="checkbox"/>
b. Decreased work hours	<input type="checkbox"/>	<input type="checkbox"/>
c. Increased work hours	<input type="checkbox"/>	<input type="checkbox"/>
d. Changed employer	<input type="checkbox"/>	<input type="checkbox"/>
e. Changed type of work	<input type="checkbox"/>	<input type="checkbox"/>
f. Changed work schedule	<input type="checkbox"/>	<input type="checkbox"/>
g. Changed position with same employer	<input type="checkbox"/>	<input type="checkbox"/>
h. Used Family Medical Leave Act	<input type="checkbox"/>	<input type="checkbox"/>
i. Lost promotion/advancement opportunities	<input type="checkbox"/>	<input type="checkbox"/>
j. Terminated from employment	<input type="checkbox"/>	<input type="checkbox"/>
k. Disciplined/Suspended	<input type="checkbox"/>	<input type="checkbox"/>
l. None	<input type="checkbox"/>	<input type="checkbox"/>
m. Other <i>(Please specify)</i> _____	<input type="checkbox"/>	<input type="checkbox"/>

34. Does your child have an IFSP (*Individualized Family Service Plan*) or IEP (*Individualized Education Plan*)?

- Yes
 No
 No, but evaluation complete, waiting for results
 I don't know
 No, but waiting for an evaluation

If your child DOES NOT have an IFSP or IEP, please SKIP to question 35

34a. At what age did your child start using Early Intervention services? _____ years _____ months

34b. How strongly do you agree or disagree with the following statement?

“My child's IFSP/IEP addresses all of my concerns for my child's development and education.”

- Strongly Agree
 Agree
 Disagree
 Strongly Disagree

34c. Did you or another family member attend your child's last IFSP/IEP meeting?

- Yes
 No

Please continue answering the questions...

35. Is your child capable of the following activities?



	Independently	With Help	Not Capable
a. Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Feeding self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Requesting things he/she needs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Requesting things he/she wants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Indicating when he/she is sick/hurt	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

36. How strongly do you agree or disagree with the following statements?

“My child is receiving all the regular care he/she needs for...”

- | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Primary Health Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Dental Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

“The individuals providing these services are able to meet my child’s needs.”

- | | Strongly Agree | Agree | Disagree | Strongly Disagree |
|-------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| c. Primary Health Care | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Dental Services | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

37. What limitations do you face accessing primary health care? *(Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Providers in the area won’t see children with autism |
| <input type="checkbox"/> Scheduling issues | <input type="checkbox"/> Cost of services/My insurance does not cover available services |
| <input type="checkbox"/> Child’s behavior problems | <input type="checkbox"/> None |
| <input type="checkbox"/> Shortage of service providers in the area | |
| <input type="checkbox"/> No service providers in the area | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |

38. What limitations do you face accessing dental services? *(Check all that apply)*

- | | |
|--|--|
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Providers in the area won’t see children with autism |
| <input type="checkbox"/> Scheduling issues | <input type="checkbox"/> Cost of services/My insurance does not cover available services |
| <input type="checkbox"/> Child’s behavior problems | <input type="checkbox"/> None |
| <input type="checkbox"/> Shortage of service providers in the area | |
| <input type="checkbox"/> No service providers in the area | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |
| <input type="checkbox"/> Other <i>(Please specify)</i> _____ | |

39. Please tell us about your child’s specialty health and education service needs:

	My child is receiving	My child is receiving, but needs more	My child is receiving, but does not need	My child is not receiving, but needs	My child is not receiving
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

40. How strongly do you agree or disagree with the following statement?

“The professionals providing this service have the necessary skills to work with my child.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

41. How strongly do you agree or disagree with the following statement?

“This service is effective in meeting my child’s needs.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Speech/Language Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Social Skills Training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. One-to-one Support (e.g. TSS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Mobile Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Case Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Neurology Services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Summer Camp	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

42. What limitations do you face accessing the specialty health and education services mentioned? *(Check all that apply)*

- Transportation
- Scheduling issues
- Child’s behavior problems
- Shortage of service providers in the area
- No service providers in the area
- Other *(Please specify)* _____
- Other *(Please specify)* _____
- Providers in the area won’t see children with autism
- Cost of services/My insurance does not cover available services
- None

43. Please tell us about your family support service needs:

	My family is receiving	My family is receiving, but needs more	My family is receiving, but does not need	My family is not receiving, but needs	My family is not receiving
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

44. How strongly do you agree or disagree with the following statement?

“The professionals providing this service have the necessary skills to work with my family.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

45. How strongly do you agree or disagree with the following statement?

“This service is effective in meeting my family’s needs.”

	Strongly Agree	Agree	Disagree	Strongly Disagree	N/A
a. Respite Care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Babysitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Daycare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Weekend Childcare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Family Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Sibling Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Sibling Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Parent Support Groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Parent Mental Health Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

46. What limitations do you face accessing the family support services mentioned? (Check all that apply)

- Transportation
- Scheduling issues
- Shortage of service providers in the area
- No service providers in the area
- Other (Please specify) _____
- Other (Please specify) _____
- Cost of services/My insurance does not cover available services
- None

47. Are there any particular service providers or organizations you would recommend to other individuals?
(Please fill out as much information as possible)

Type of Service:	
Name of Provider:	
Organization:	
Address:	

Type of Service:	
Name of Provider:	
Organization:	
Address:	

Type of Service:	
Name of Provider:	
Organization:	
Address:	



*Thank you for completing this needs assessment survey.
Please send the completed survey in the
self-addressed and stamped envelope.*

