

2022 Community Assessment

The purpose of this survey is to better understand what families need in order to improve and add to our Head Start services. Your feedback is very important and will be kept confidential. Thank you for taking the time to answer these questions. ***Please fill out only one survey per family.***

**Tell Us about Yourself**

1. What category best describes you?

Parent working in the home Parent working outside the home Parent in school Foster parent Grandparent/Guardian Single parent

Teen parent in school Teen parent working other

1. Your gender/sex:

Male Female

1. Your age:

|  |  |  |
| --- | --- | --- |
| 15 and under | 16-21 | 22-27 |
| 28-33 | 34-39 | 40-45 |
| 46-51 | 52-59 | 60 and over |

1. Your ethnicity/race:

Asian/Pacific Islander

Other

Alaskan African-American

White/Anglo Caucasian Hispanic

1. What is the primary language spoken in your home? English

Spanish

Other

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1. Are you or your spouse a Head Start graduate?

*Yourself Spouse/Partner*

Yes No

1. How many of your family members attended Head Start?
2. How important is spirituality in the lives of your child, yourself and family.

9.

1. Describe the traditional practices used in your family.

**Tell Us about Your Family**

1. What is your marital status?

Single Married Divorced

Separated

Other

Living with my partner Widowed 1

1. Which of the following best describes your family? [Check only one]

Two Parent Family Single female head of household Single male head of household other

1. How many family members reside in your home?
2. How many adults, including yourself, live in your household?
3. Which category best represents the age of the head of household? [Check only one]

|  |  |  |
| --- | --- | --- |
| 18-24 | 25-34 | 35-44 |
| 45-54 | 55-64 | 65 or older |

1. How many children live with you? (under 18 years old)

How old is each child?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Child #1** | **Child #2** | **Child #3** | **Child #4** | **Child #5** |
| 0 to 2 years old |  |  |  |  |  |
| 3 to 5 years old |  |  |  |  |  |
| 6 to 13 years old |  |  |  |  |  |
| 14 to 17 years old |  |  |  |  |  |

**Tell Us about Your Family’s Home**

1. List the community that you live in
2. Are you currently homeless?

Yes No

1. Have you ever been homeless?

Yes No

If so, for how long?

1. About your home, does your family

Rent Live with other people Own Other

1. What type of home do you have?

Adobe/Stone HUD/Manufactured Trailer Other

1. About your living situation, does your family live

Alone as a family with relatives with friends

In a shelter other

1. How often are these statements true about your housing? **Never Sometimes Often Always**

*Our housing is…* **True True True True**

Just the right size

Crowded

Needs major repairs Old and aged

Kept in good condition

1. Does your home have adequate plumbing? Yes No

**Tell Us about Your Family’s Health Care**

1. What type of health insurance do you have?

None Medicaid Provided through work Private

If not insured, what are the main reasons why? [Check all that apply]

Don’t know how or where to get it Job doesn’t provide it Don’t need it

Can’t afford it Don’t qualify for it Other

If you do not have insurance, are you eligible for Medicaid?

No Yes Don’t know

1. What type of insurance do(es) your child(ren) have?

Same insurance Not insured Other

If not insured, what are the main reasons why? [Check all that apply]

Don’t know how or where to get it Job doesn’t provide it Don’t need it

Can’t afford it Don’t qualify for it Other

1. Where do you usually take your child to get medical care? [Check all that apply]

Family doctor Community health clinic Emergency room

Family dentist IHS Other

1. What type of dental insurance do you have?

None Medicaid Provided through work Private

1. What type of dental insurance do(es) your child(ren) have?

Same insurance Not insured Other

**Tell Us about Your Employment**

1. Are you currently employed?

*You Spouse*

Not employed Employed, full-time Employed, part-time

Self employed If not, what keeps you from employment?

Lack of child care

Fear of losing public assistance

No transportation In School

Lack of Skills

Other

1. Are other adult members in your family employed? [Check one for each if applicable]

*Member 1 Member 2*

Not employed Employed, full-time Employed, part-time

Self employed

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**Tell Us about Your Income**

1. What is your annual household income?

Less than $10,000 $10,000 - $14,999 $15,000 - $24,999

$25,000 - $34,999 $35,000 - $44,999 $45,000 - $54,999

$55,000 - $64,999 $65,000 and over

1. In what industry is the major wage earner in your home employed? [Circle number]
   1. Agriculture
   2. Construction
   3. Manufacturing
   4. Retail/Wholesale
   5. Transportation, Communications, and Public Utilities
   6. Finance, Insurance, Real Estate
   7. Government (Includes Education)
   8. Services (Includes Retail)
   9. Retired
   10. Homemaker
   11. Craftsperson
2. Are you entitled to receive child support or alimony?

No Yes, child support Yes, alimony

1. Do you receive your child support or alimony?

No Yes, but rarely Yes, sometimes

Yes, most of the time Yes, always

1. Do you receive Public Assistance?

Yes No

If so, Please Indicate.

Medicaid TANF Social Security

Food Stamps Commodities SSI

Housing Workers Compensation Unemployment Benefits Other

**Tell Us about Your Transportation**

1. How does your child get to Head Start?

Car Look for a ride Other

1. Is your family in need of transportation? Yes No

**Tell Us about Your Education**

1. Indicate the highest level of education completed by household:

*Yourself Spouse/Partner Other Adult*

Some high school High School graduate Vocational school Some College

AA degree (2 year degree) Bachelor’s degree

Some graduate school Master’s Degree

1. Are you, your spouse/partner or other household member currently in school?

*Yourself Spouse/Partner Other Adult*

No

Yes, full-time Yes, part-time Other

1. If you, your spouse/partner or other household member are in school, what type of school?

*Yourself Spouse/Partner Other Adult*

Working on GED Vocational School

College Other

1. If you are not in school, do you, your spouse/partner or household member want to attend school in the future?

*Yourself Spouse/Partner Other Adult*

No Yes

1. If No, explain why?

**Tell Us about Services in Your Community**

1. Who or where do you turn for assistance most often?

|  |  |  |
| --- | --- | --- |
| Church | Health clinic | Friend |
| Teacher | Family member | Co-worker |
| Child care center | Social services | Other |

1. Which Community Service do you receive and how adequate are they:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Use** |  | **Don’t**  **Know** | **Not**  **Available** | **Poor** | **Good** | **Excellent** |
|  | Child Care |  |  |  |  |  |
|  | Community & Church organizations |  |  |  |  |  |
|  | Crisis Intervention & Counseling |  |  |  |  |  |
|  | Education & Literacy |  |  |  |  |  |
|  | Employment & Training |  |  |  |  |  |
|  | Mental Health Services |  |  |  |  |  |
|  | Substance Abuse Treatment |  |  |  |  |  |
|  | Emergency Assistance (EMS/Fire Dept.) |  |  |  |  |  |
|  | Child Welfare & Foster Care |  |  |  |  |  |
|  | Law Enforcement |  |  |  |  |  |
|  | Culture |  |  |  |  |  |
|  | Transportation |  |  |  |  |  |
|  | Family Support Services |  |  |  |  |  |
|  | Health |  |  |  |  |  |
|  | Public Health Services |  |  |  |  |  |
|  | Roads Maintenance |  |  |  |  |  |
|  | Housing Needs |  |  |  |  |  |
|  | Solid Waste Management |  |  |  |  |  |
|  | Legal aid |  |  |  |  |  |
|  |  |  |  |  |  |  |

**Tell us about your Special Needs**

1. Do you have a child with special needs?

Yes No

How old is this child?

1. Have you ever been involved in the referral process (e.g. referral meeting, permission, consent, etc.)? Yes No
2. What type of disability or special need does your child have?

|  |  |  |
| --- | --- | --- |
| Speech and Language Autism  Health Impairment | Mental Retardation Hearing Impairment  Visual Impairment | Non Categorical/Dev. Delay Learning Disabilities  Multiple Disabilities |
| 52. Where does your child receive services? TANF | EBT Assistance |  |
| Head Start | Other |  |

1. If your child is receiving therapy services, would you like those services to continue throughout the summer? Yes No
2. Which services is your child receiving?

Occupational Therapy Behavioral/Mental Health Other Physical Therapy Speech and Language

**Tell Us How We Are Doing**

1. How did you hear about Lyn-CAG Head Start?

Friends/relatives Head Start flyer or brochure

Head Start staff Newspaper

Other Head Start Parent

1. Have you volunteered in the Head Start Program? Yes No

If yes, please check all of the ways you have volunteered?

|  |  |  |
| --- | --- | --- |
| Helping in the classroom | Helping with Events | Helping on the bus |
| Serving on Parent/Ed. Committee | Community Action Team (CAT) | Helping with cooking |
| Serving on Policy Council | Special Projects | Health Advisory Comm. |
| Other |  |  |

How would you rate your experience?

Very good Good

Needs Improvement Unacceptable

If no, why haven’t you volunteered?

1. To help us plan for the future would you please tell us what program would best fit your needs?

* Full Day- School Year programming 5 days per week for 8 hours per day
* Half Day- School Year programming 5 days per week for 5 hours per day
* Extended hour programming 5 days per week for up to 10 hours per day
* Something else: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your Current Experience

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Please Check One:** | **Very Good** | **Good** | **Needs**  **Improvement** | **Unacceptable** |
| How understandable was the orientation you received to participate in the Head Start Program? |  |  |  |  |
| How understandable are the application forms? |  |  |  |  |
| How well do you think the staff answer your questions? |  |  |  |  |
| How adequate is the number of contacts with Head Start staff? |  |  |  |  |
| How comfortable are you speaking with Head Start staff? |  |  |  |  |
| How well are Head Start staff meeting your family's needs? |  |  |  |  |
| How well do you think staff are at doing what they say they will do? |  |  |  |  |
| How well do you think Head Start is doing in assisting in your child's education? |  |  |  |  |
| How well are you treated by staff? |  |  |  |  |
| How well do you think staff respect your opinions, ideas, and concerns? |  |  |  |  |
| How prompt are actions taken by staff to deliver services? |  |  |  |  |
| How well do you think staff know you and your family? |  |  |  |  |
| How would you rate the individualized attention your family receives from Head Start? |  |  |  |  |
| Overall, how would you rate your child's experience in the classroom? |  |  |  |  |
| Overall, how would you rate your experience in the Head Start program? |  |  |  |  |

1. What areas of the Head Start program do you feel could use improvement? (Check all that apply) Education/Literacy Nutrition & Meal Service Transportation Health Assessment/Follow-up Disabilities Assessment/Follow-up Culture Family/Community Partnerships Classroom environment Mental Health Curriculum Communication
2. Please list suggested improvements for the program.