## A. Health and Well-Being Assessment Survey

The *Passaic County Health Department* is sponsoring this survey. All your responses are confidential. (Your name will not appear with your answers)

Please use a pen to answer the questions on both sides of this form. Please mark your answer choice within the box, like this: [X]

**1. What is the name of the town in which you live?** _____

**2. How old are you?**

- ☐ 18 to 29 years
- ☐ 30 to 44 years
- ☐ 45 to 54 years
- ☐ 55 to 64 years
- ☐ 65 to 74 years
- ☐ 75 years and older

**3. Are you male or female?**

- ☐ Male
- ☐ Female

**4. How would you refer to yourself?**
*(Please mark all that apply)*

- ☐ Asian/Asian-American
- ☐ Black/African-American
- ☐ White/Caucasian
- ☐ Hispanic/Latino
- ☐ Other (SPECIFY):_____

**5. Where do you live?**

- ☐ Single-family home
- ☐ Attached home
- ☐ Apartment/Condo
- ☐ Mobile home
- ☐ Other (SPECIFY):_____

**6. How many people live in your household, including yourself?**

☐ One ☐ Two ☐ Three ☐ Four ☐ Five or more

**7. Were you personally affected by Superstorm Sandy?** ☐ Yes ☐ No

**7a. If yes, how were you affected?** *(Mark all that apply)*

- ☐ Lost power. If so, for how long? _____
- ☐ Home was damaged
- ☐ Car was damaged
- ☐ Had to visit the hospital for Medical Care
- ☐ Had to stay away from home: If so, where did you go?
  - ☐ Friend/family/neighbor's house
  - ☐ Shelter
  - ☐ Hotel
  - ☐ Other:_____
- ☐ Other (SPECIFY):_____

**8. Did you have any loss of income due to the storm?** ☐ Yes ☐ No

**8a**. If yes, was loss of income ☐ temporary (less than 6 months) or ☐ permanent (more than 6 months)?

**9. As a result of Superstorm Sandy, did you need service provider assistance, such as a visiting nurse, meal delivery, or other home-based care service?** □ Yes □ No

**9a.** If yes, is this service still being provided to you? □ Yes □No

**10. Were you displaced from your home due to Superstorm Sandy?** □ Yes □No

**10a.** If yes, are you still displaced? □ Yes □No

**11. Are you aware of the following types of resources? Are you still in need of this type of resource(s)?** *(Please mark all that apply)*

| **Type of Resources** | | **Are you still in need of this type of resource?** |
|---|---|---|
| Case Management | □ Yes □No | □ Yes □No |
| Counseling Services | □ Yes □No | □ Yes □No |
| Federal Emergency Management Agency (FEMA) | □ Yes □No | □ Yes □No |
| NJ Hope and Healing | □ Yes □No | □ Yes □No |
| NJ 211 | □ Yes □No | □ Yes □No |
| NJ Register Ready | □ Yes □No | □ Yes □No |
| Sandy Homeowner and Renter Assistanc Program (SHRAP) | □ Yes □No | □ Yes □No |
| United Way/Red Cross/Charity | □ Yes □No | □ Yes □No |
| Other NJ State Programs (SPECIFY):_____ | | □ Yes □No |
| Other Sources (SPECIFY): _____ | | □ Yes □No |

**12. How would you say your health was, in general, before and after Superstorm Sandy?**

| | Very Good | Good | Neither good nor poor | Poor | Very Poor |
|---|---|---|---|---|---|
| Before Superstorm Sandy | □ | □ | □ | □ | □ |
| After Superstorm Sandy | □ | □ | □ | □ | □ |

**13. As a result of Superstorm Sandy, what are your concerns with your health and overall well-being?** *(Please mark all that apply)*

- ☐ Work/Working (jobs/employment)
- ☐ Having enough money
- ☐ Having good neighborhood/ neighbors
- ☐ Having a caring family/relationship
- ☐ Having a safe place to live (mold, asbestos, lead, and other contamination from the flood)
- ☐ Language barriers in understanding the recovery resources available
- ☐ Housing
- ☐ Mood
- ☐ Transportation
- ☐ Having access to affordable healthy food
- ☐ Using the recovery resources (internet, phone, filling out the paper work)
- ☐ Other (SPECIFY):_____
- ☐ Physical activity
- ☐ Alcohol drinking
- ☐ Drug abuse
- ☐ Affordable health care services
- ☐ Experiencing abuse and violence

**14. As a result of Superstorm Sandy, have you experienced any of the following:** *(Please mark all that apply)*

- ☐ Recurring dreams or nightmares about the storms or floods
- ☐ Trouble concentrating or remembering things
- ☐ Feeling numb, withdrawn or disconnected
- ☐ Having bursts of anger or intense irritability
- ☐ Persistent physical symptoms (headaches, digestive problems, muscle tension, etc.)
- ☐ Being overprotective of your family's safety
- ☐ Avoiding reminders of the storm or flood
- ☐ Being tearful or crying for no apparent reason
- ☐ Permanent Disability (physical or mental)

**15. As a result of Superstorm Sandy, what types of services do you still need?** *(Please mark all that apply)*

- ☐ Medical assistance
- ☐ Money assistance
- ☐ Assistance with government grants
- ☐ Counseling for children
- ☐ Counseling for depression, anxie lack of sleep, or panic attacks
- ☐ Treatment for alcohol or drug abuse
- ☐ Transportation
- ☐ Domestic violence counseling
- ☐ Home repair, replacement of household contents

☐ Food assistance

☐ Mold inspection/ removal

☐ Housing

☐ Assistance with translating services

☐ Lead inspection

☐ Information, referral, advic

☐ Other health related needs (SPECIFY):_____

**16. What best describes how you are recovering from Superstorm Sandy?**

☐ Completely recovered
☐ Mostly recovered
☐ Recovered about halfway
☐ Recovered a little
☐ Not recovered at all

**17. Do you have any special conditions that are preventing you from recovering?**
*(Please specify)*

_____

_____

_____

**If you feel that you still need assistance because of how you were impacted by Superstorm Sandy please contact your Local Health Department:**

PASSAIC COUNTY HEALTH DEPARTMENT
973-881-4396 (Office)
973-225-0222 (Fax)

**Thank you for your time and cooperation!**