Jefferson County Office for the Aging Needs Assessments

Personal Information- *Required			
*First Name:	*Last Name:		
*Address:	City:	State:	Zip:
*Phone Number:	*Date of Birth:		

Questionnaire	Yes	No
1. Do you need help getting an appointment for a COVID Vaccine?		
2. Do you need help in providing for your meals?		
3. Do you need help with transportation getting to appointments?		
4. Do you need help getting healthcare?		
5. Do you need help affording utilities?		
6. Do you need help affording your medication?		
7. Do you need help affording proper housing?		
8. Do you need help providing care for another person?		
9. Do you have financial problems?		
10. Do you need help performing every day activities such as bathing or walking?		
11. Do you feel sad or lonely?		
12. Are you a victim of a crime?		
13. Do you have a disability?		
14. Are you in good health?		
15. How many people live in the house besides you? [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] Other:		
16. Have you used Jefferson County Office for the Aging services previously?		
17. Would you like Jefferson County Office for the Aging to contact you and see what services we can provide to you?*		