KAISER PERMANENTE®

DIVISION OF RESEARCH
Northern California

2020 KAISER PERMANENTE MEMBER HEALTH SURVEY

CONFIDENTIAL

This questionnaire should only be completed for:

Do we have your correct information?
Please print any CHANGES below.

Address: _____

_____

Daytime phone: (_____) _____

Email address: _____

We are doing this survey to learn about our adult membership's health-related needs and preferred methods of communication with Kaiser Permanente about their health and health care.

IMPORTANT:

- **This questionnaire should be filled out *ONLY* for the person whose name is printed above.**
- **YOUR information is very important even if you are healthy, rarely use Kaiser Permanente services, or are not totally happy with the services you have received.**
- **To complete this online, go to www.mhs2020.kaiser.org/sr or email me at nancy.gordon@kp.org and I will email you a link to the online questionnaire.**
- **Mark the box with an X or ✓ to indicate your answer. You may skip any question you do not want to answer.**
- **YOU will be entered into a drawing for one of 100 $100 gift cards when we receive your completed questionnaire *(make your selection below).***

Your answers are absolutely confidential. They will not become part of your health records or shared with your doctors or anyone outside the Division of Research in a way that identifies you. Your name and Study ID are on the questionnaire so we can note that you returned it and contact you if needed. Your participation is voluntary. If you have any questions about the survey, please call toll-free: **(800) 723-8055 (choose Member Health Surveys)** or email me at **nancy.gordon@kp.org**.

Please return your completed survey in the enclosed postage-paid envelope to:
Kaiser Permanente Division of Research, 2000 Broadway, Oakland, CA 94612 attn: NPG

Thank you for taking the time to do this!

Nancy Gordon, ScD
Member Health Survey Director

Which of these $100 gift cards would you choose if you win the drawing?

☐ **Target** ☐ **Amazon.com**

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Your Health and Health-Related Habits

1. In general, would you say your health is:

☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

2. Health can be thought of as having two components, physical health (including pain) and emotional well-being or mental health (such as whether you feel depressed or anxious). In general, how would you rate:

	Excellent	Very Good	Good	Fair	Poor
a. Your physical health	☐	☐	☐	☐	☐
b. Your emotional/mental health	☐	☐	☐	☐	☐

3. How much does your health interfere with your work or other regular daily activities?

	Not at All	A Little Bit	Moderately	Quite a Bit
a. Your physical health (including pain)	☐	☐	☐	☐
b. Your emotional/mental health	☐	☐	☐	☐

4. During the <u>past 12 months</u>, which of these health conditions or problems did <u>you</u> have or were <u>you</u> treated for? *(Mark ALL you had, were treated for, or used medication or special diet for)*

☐ High blood pressure *(diagnosed by a clinician)*
☐ Heart disease (e.g., heart attack, angina, blocked artery, atrial fibrillation, congestive heart failure)
☐ Diabetes *(other than only during pregnancy)*
☐ Prediabetes
☐ High cholesterol *(diagnosed by a clinician)*
☐ Stroke
☐ Cancer *(specify type):*_____
☐ Asthma
☐ COPD, emphysema, or chronic bronchitis
☐ Osteoarthritis *("wear and tear" arthritis)*
☐ Severe back pain or sciatica
☐ Severe neck or shoulder pain
☐ Migraine headaches
☐ Other type of severe headaches
☐ Chronic (frequent or ongoing) pain
☐ Frequent heartburn or acid reflux (GERD)
☐ Frequent constipation or very hard stools ("poops")
☐ Urine leakage at least once a week *(describe):*
  ☐ After feeling pressure to urinate
  ☐ When coughing, lifting, exercising, etc.
☐ Vision problem (with or without glasses/lenses)
☐ Problems with hearing and/or deafness
☐ Frequent problems with balance or walking
☐ Frequent problems with memory
☐ Frequent problems falling or staying asleep
☐ Frequently felt *very* sleepy/tired during the time of day you normally work or do other daily activities
☐ Frequent very loud snoring
☐ Sometimes stopped breathing in your sleep or woke up feeling like you were choking or gasping for air
☐ Depression, sadness, or very low spirits that lasted at least 2 weeks
☐ Anxiety or panic that lasted at least 2 weeks
☐ **None of these problems or conditions**

5. Have you <u>EVER</u> had: *(Mark ALL that apply)*

☐ Heart disease, heart surgery, or a heart attack
☐ Cancer *(specify type)*: _____
☐ A stroke
☐ High blood pressure (hypertension)
☐ Diabetes *(other than only during pregnancy)*
☐ Sleep apnea (OSA)
☐ Adult depression lasting at least 2 weeks
☐ Chronic (ongoing) pain *(describe)*:_____
☐ Problems with alcohol or drugs
☐ A hysterectomy ***(Women only)***
☐ **None of these**

6. In the <u>past 12 months</u>, how many times have you fallen to the ground or fallen on stairs? *(If you had no falls write "0")* ____ *Falls*

7. Do you have problems with your teeth, gums, or mouth that make it difficult to eat or talk? ☐ Yes ☐ No

8. Do you regularly use a hearing aid?

☐ Yes ☐ No ☐ I am deaf or have a hearing problem that a hearing aid won't help

9. Do you have difficulty driving, or watching TV or reading, or doing any of your daily activities because of your eyesight? ☐ Yes ☐ No ☐ I am legally blind

10. Which of the following describes your situation? ***(Mark ALL that apply)***

☐ I usually need help from another person to move around
☐ I usually use a motorized wheel chair or motorized scooter to move around
☐ I usually use a cane, walker, or poles when I walk around
☐ I don't need help from another person or special aid, but have some trouble getting around
☐ I am not limited at all in my ability to get around

11. Do you need help from another person with any of these activities? ***(Mark ALL that apply)***

☐ Getting to places out of walking distance
☐ Shopping for groceries, etc.
☐ Doing routine household chores
☐ Preparing meals
☐ Managing your finances/money
☐ Managing and taking your medicines
☐ Communicating with your health care providers
☐ Getting in and out of bed or chairs
☐ Using the telephone
☐ Bathing in a tub or shower
☐ Dressing
☐ Eating food and drinking liquids
☐ Using the toilet
☐ Cutting your toe nails

12. If for any reason you need help with activities of daily living such as bathing, preparing meals, shopping, managing finances, etc., do you get the help that you need? ***(Mark ONE only)***

☐ Don't need any help ☐ Get all the help I need ☐ Could use a little more help ☐ Could use a lot more help

13. Considering all things, how well can you take care of yourself at this time? ***(Mark ONE only)***

☐ Not at all able ☐ Not very well ☐ Fairly well ☐ Very well ☐ Completely able

14. If you became too sick, injured or frail to take care of yourself, is there <u>at least</u> one person living near you who would help take care of your needs or arrange for the help/care you would need?

☐ Yes → **Who would be available to help you?** ☐ Spouse/partner ☐ Relative ☐ Friend ☐ Other
☐ No

15. During the <u>past 12 months</u>, did you use any of the following prescription or non-prescription ("over the counter") medicines <u>at least twice a week</u>? ***(Mark ALL that apply)***

☐ Low dose aspirin to prevent stroke, heart attack, or cancer
☐ Asthma medicine or spray
☐ Heart medicine (not including aspirin)
☐ High blood pressure medicine
☐ Insulin or other diabetes medicine
☐ Cholesterol/lipid lowering medicine
☐ Osteoporosis medicine
☐ Heartburn/acid reflux medicine *(Pepcid, etc.)*
☐ Laxatives/other products for constipation
☐ Anti-inflammatory medicine *(NSAIDS like Advil, ibuprofen, etc.)*
☐ Prescription pain medicine
☐ Non-prescription (OTC) pain medicine
☐ Prescription or non-prescription sleep medicine
☐ Nicotine gum or patch, other quit smoking medicine
☐ Prescription or non-prescription weight loss medicine
☐ Prescription medicine for depression
☐ Prescription medicine for anxiety or panic
☐ **None of these**

16. How many <u>prescription</u> medicines do you regularly take? _____ *Prescription medicines*

17. During the <u>past 12 months</u>, did you use any herbals, nutritional supplements, or other "natural" remedies <u>to treat or prevent your own health problems</u>? ***(Mark ALL that apply and list others)***

☐ Daily multivitamin
☐ Calcium with or without vitamin D included
☐ Vitamin D (separate from calcium or multivitamin)
☐ Fish oil, flaxseed oil, other omega-3 fatty acids
☐ Probiotics
☐ Glucosamine
☐ Melatonin or sleep formula containing melatonin
☐ Any herbal medicines/remedies/supplements
☐ Other vitamins or supplements:_____

18. During the past 12 months, did you use any of the following methods to help manage or prevent your own health problems? *(Mark ALL that apply)*

- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Massage therapy
- ☐ Yoga or Pilates
- ☐ Tai Chi, Chi Gong
- ☐ Deep breathing, mindfulness meditation, or other mind-body stress management technique
- ☐ Vegetarian or vegan diet
- ☐ Other special diet:_____
- ☐ Prayer or spiritual practice you do yourself
- ☐ Religious or spiritual healing by others
- ☐ Psychological counseling or therapy
- ☐ 12-Step program or other self-help/support group
- ☐ **None of these**

19. How tall are you without shoes? _____ *Feet* _____ *Inches*

20. How much do you weigh without your shoes and clothes? ____ *Pounds*

21. During an average day, about how many servings of fruits and vegetables do you usually eat? *(1 serving = a half cup or a medium piece)* ____ *Servings per day*

22. How many days per week do you usually drink one or more sugar- or corn syrup-sweetened drinks like regular soda, fruit drinks, vitamin water, bottled teas, coffee drinks, sports drinks (e.g., Gatorade), and energy drinks (e.g., Red Bull)? *Do not count diet drinks.*

☐ Every day ☐ 6 days ☐ 5 days ☐ 4 days ☐ 3 days ☐ 2 days ☐ 1 day ☐ Less than once a week/never

23. How often do you try to avoid eating foods that are high in salt or sodium (like most canned, packaged, processed, and "fast" foods and foods seasoned with a lot of salt)?

☐ All the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ Never

24. How often do you usually do physical activity or exercise (such as walking, running, swimming, tennis, soccer, gardening, dancing, yoga, exercise class, etc.)?

☐ 7 days/week ☐ 5 days/week ☐ 3 days/week ☐ 1 day/week ☐ Never → ***If NEVER, go to Question 25***
☐ 6 days/week ☐ 4 days/week ☐ 2 days/week ☐ Less than once a week

24a. On days you exercise, how many total minutes do you usually exercise? ___ *Minutes per day*

24b. On days you exercise, what type of exercise do you usually get? *(Mark ONE only)*

- ☐ Light (barely increasing your breathing and heart rate, like an easy walk or swim)
- ☐ Moderate (noticeably increasing your breathing and heart rate, like walking fast or uphill)
- ☐ Vigorous (causing a large increase in your breathing and heart rate, like running or swimming fast)

25. Do you smoke cigarettes now, even occasionally?

☐ NO, and I never smoked or I smoked less than 100 cigarettes in my lifetime

☐ NO, but I used to smoke regularly → ***Answer a-c***

a. When did you last smoke? ☐ Less than 6 months ago ☐ 1-5 years ago ☐ 6-12 months ago ☐ Over 5 years ago

b. How many total years did you smoke? _____ *Years*

c. How often did you usually smoke? ☐ Every day ☐ Some days ☐ Very rarely

☐ YES, I smoke → ***Answer d-g***

d. How often do you usually smoke? ☐ Every day ☐ Some days ☐ Very rarely

e. How many cigarettes do you usually smoke per day? _____ *Cigarettes*

f. How many total years have you smoked? _____ *Years*

g.Did you make a serious attempt to quit smoking in the past year? ☐ Yes ☐ No

26. During the past 12 months, did you use any of the following? *(Mark ALL that apply)*

☐ E-cigarettes, vape pens, or e-hookah ☐ Pipe ☐ Cigars ☐ Bidis ☐ Hookah or water pipe
☐ Smokeless tobacco (e.g., snuff, chew, dip, paan, snus, betel) ☐ Nicotine gum

27. During the <u>past 12 months</u>, how often have you usually had a drink containing alcohol?

☐ Almost every day
☐ 5 to 6 times a week
☐ 3 to 4 times a week
☐ 1 to 2 times a week
☐ 2-4 times a month
☐ 1 time a month or less
☐ Never in the past 12 months *(used to drink)*
☐ Never in the past 12 months *(never drank as adult)*

} ***If NEVER, go to Question 28***

27a. On days when you had a drink, how many drinks did you usually have?
(1 drink = a 12-oz. can of beer, 5 oz. of wine, or a 1 oz. shot of hard liquor) ____ *Drinks*

28. On a typical <u>weekday</u>, how many <u>total hours</u> of sleep do you usually get, including naps? ____ *Hours*

29. How would you rate the usual quality of your sleep?
☐ Very good ☐ Good ☐ Fair ☐ Poor ☐ Very poor

30. During the <u>past 12 months</u>, how often have you felt very stressed, tense or anxious?
☐ Never ☐ A little of the time ☐ Some of the time ☐ Much of the time ☐ Most of the time

31. How often do you get the social and emotional support you need?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

32. How often do you feel lonely or isolated from those around you?
☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always

33. In general, how satisfied are you with your life?
☐ Very satisfied ☐ Satisfied ☐ Dissatisfied ☐ Very dissatisfied

34. Are you currently doing any of the following to improve or maintain your health?
(Mark ALL that apply)

☐ Get moderate or vigorous exercise most days
☐ Take walks for at least 30 minutes most days
☐ Taking steps to quit smoking or stay off cigarettes
☐ Taking steps to lose weight or maintain weight loss
☐ Learn what is in food by reading labels/recipes
☐ Try to eat mostly healthy foods
☐ Try to manage stress effectively
☐ Try to get enough sleep to feel well-rested
☐ Get annual dental checkup and teeth cleaning
☐ Do enjoyable activities at least once a week
☐ Do activities to keep your brain stimulated
☐ Visit with people at least once a week
☐ Take all medicines as prescribed
☐ Take actions to reduce risk of falling

35. How much do you think habits/lifestyle (such as exercise, what you eat, and your weight) can affect your health?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

36. How much do you think stress and emotional troubles (such as depression or anxiety) can affect your health?
☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely

37. During the <u>past 12 months</u>, did any of these situations or problems occur? ***(Mark ALL that apply)***

☐ You were **physically or emotionally hurt or felt threatened** by a current or former spouse/partner, family member, or someone else you knew
☐ You felt **harassed or discriminated against**
☐ You worried about your or your family's **safety due to neighborhood violence**, robberies, etc.
☐ You worried a great deal about your or your family's **financial security**
☐ You had **problems "making ends meet"** at the end of a month
☐ You worried that **your food might run** out before you had money to buy more
☐ You worried that you **might not be able to pay for needed medical care** or medicine/medical supplies
☐ **Other major life stress** such as loss of a job, separation/divorce, death of a loved one, disaster, etc.

38. During the <u>past 12 months</u>, did you provide <u>unpaid</u> care to a relative or friend who is or was seriously ill or has a physical, developmental, mental, or emotional disability?
(Helping with personal needs, managing finances, arranging for services, etc.) ☐ Yes ☐ No

39. During the past 12 months, did you:

a. Take a medicine in smaller doses or less frequently than prescribed, or decide not to fill a prescription *because of the cost?* ☐ Yes ☐ No

b. Delay or not get medical care you thought you needed *because of the cost?* ☐ Yes ☐ No

c. Delay or not get dental care *because of the cost?* ☐ Yes ☐ No

d. Eat less fruit, vegetables, and other healthy foods *because of the cost?* ☐ Yes ☐ No

Health-Related Care Inside and Outside of Kaiser Permanente

40. Did you get a flu (influenza) shot between September 2019 and March 31, 2020?
☐ Yes, at Kaiser Permanente ☐ Yes, outside Kaiser Permanente ☐ No

41. When did you last have your teeth cleaned and checked by a dentist or dental hygienist?
☐ Less than 7 months ago ☐ 7-12 months ago ☐ More than 1 year ago ☐ Never had this done

42. Do you have insurance that pays for routine dental check-ups and teeth cleaning? ☐ Yes ☐ No

43. During the past 12 months, how many visits to non-Kaiser Permanente health professionals (doctor, chiropractor, etc.) did you make for your own health? (*Do NOT include dentists*) ____ *Visits*

44. Do you have insurance that helps pay for costs of non-Kaiser Permanente medical visits? ☐ Yes ☐ No

45. During the past 12 months, how many of your own prescriptions did you get filled at non-Kaiser Permanente (KP) pharmacies and/or through non-KP websites? ____ *Prescriptions*

46. During the past 12 months, did you frequently use any of the following services for yourself? ***(Mark ALL that apply)***

☐ Housekeeper or house cleaner
☐ Home-delivered meals
☐ Shopping/food delivery service
☐ Transportation service (e.g., paratransit)
☐ Paid caregiver, companion or attendant
☐ Unpaid caregiver (e.g., relative or friend)

47. Do you have any advance directives for your health care (for example, Living Will, Life Care Planning, Medical Durable Power of Attorney, or Five Wishes)? ☐ Yes ☐ No

48. In the past 12 months, have you talked with or received recommendations from a Kaiser Permanente doctor, nurse, health educator, health coach, or other KP health care professional about: ***(Mark ALL that apply)***

☐ Your diet (salt, fats, fiber, etc.)
☐ Losing weight
☐ Getting enough exercise
☐ Getting enough sleep
☐ Quitting smoking
☐ Stress or emotional problems like depression or anxiety
☐ How to reduce your risk of falling
☐ Health screening tests and shots recommended for you
☐ Getting routine dental/mouth exams and teeth cleaning
☐ A review of all the medicines and supplements you take

49. How would you rate Kaiser Permanente on the information and advice you've received about how to improve your health and well-being?
☐ Excellent ☐ Very good ☐ Good ☐ Fair ☐ Poor

Your Communication Tools and Preferences

50. Do you have any of the following types of mobile devices? ***(Mark ALL that apply)***
☐ Cell phone ☐ Smartphone (e.g., iPhone, Android) ☐ Tablet enabled for wi-fi ☐ None of these

51. Do you have access to a desktop, laptop or tablet computer that you can (or could) use to go online (use the Internet)? ***(Mark ALL that apply)***
☐ Yes, at home ☐ Yes, at work ☐ Yes, at another location (library, neighbor, etc.) ☐ No access

52. Do you use the Internet (go online) to get information, watch videos, fill out forms, pay for things, etc.?

☐ Yes, I use it by myself
☐ Yes, but someone else helps or uses it for me
☐ No, I don't use the Internet

a. What device(s) do you/your helper usually use to go online?
☐ Desktop or laptop computer ☐ Tablet (e.g., iPad) ☐ E-reader
☐ Cell phone ☐ Smartphone ☐ Other:_____

b. Can you easily print information/forms you get from the Internet?
☐ Yes, at home ☐ Yes, at another location ☐ No

53. If you use the Internet, where do you use it: ☐ At home ☐ At work ☐ Other:_____ ☐ Don't use it

54. Are you able to send and receive/check email, and if so, what type of device do you use for email?

☐ Yes, I do this myself
☐ Yes, but someone else helps or does this for me
☐ No, I don't use email

What device(s) do you/your helper usually use to send/check email?
☐ Desktop or laptop computer ☐ Cell phone ☐ Smartphone
☐ Tablet (e.g., iPad) ☐ Other:_____

55. Are you able to: ☐ Send and receive text messages ☐ Use apps

56. Would you be willing to enter information into an online questionnaire/form on the kp.org website if you were sent a link by email or kp.org secure message? ☐ Yes ☐ No ☐ Not sure

57. During the <u>past 12 months</u>, have you done any of the following? ***(Mark ALL that apply)***

☐ Participated in any Kaiser Permanente group or individual **health education program/service**
☐ Used any **quit smoking program/service** (wellness coach, group, phone quit line, web-based, etc.)
☐ Used any **weight loss or Healthy Eating, Active Living program/service** (wellness coach, group, individual in-person counseling, web-based, email-based, etc.)
☐ Got help from a Kaiser Permanente **health educator** or **wellness coach** with **changing health-related behaviors** (e.g., diet, exercise) or **managing a chronic health condition** like diabetes
☐ Used Kaiser Permanente **print health education materials** (handouts, pamphlets, etc.)
☐ Got health or medication-related **information** or advice from **Kaiser Permanente's website**
☐ Got health or medication-related **information** or advice from a **non-Kaiser Permanente website**
☐ Got health information from your **doctor's home page on the Kaiser Permanente website**
☐ Used any **online education videos on a Kaiser Permanente website** (preparing for a procedure or surgery, managing pain, or healthy lifestyle for weight loss, stress, etc.)
☐ Listened to a **kp.org podcast**
☐ Used any **health app** to help with diet, exercise, sleep, monitoring a health condition, etc.
☐ Used the **kp.org website** to **view lab results, refill prescriptions, or email** doctors/other staff
☐ Used **a Kaiser Permanente app** to use the kp.org website's secure features or get reminders
☐ **I did not do any of these things**

58. In which of these ways would you prefer to get information and advice about how to manage health conditions and make changes in health behaviors (diet, exercise, etc.)? ***(Mark ALL that apply)***

☐ **Telephone sessions** with a **wellness coach**
☐ **In-person counseling** with a patient educator
☐ **Video visit** with a patient educator
☐ **Video visit** with a doctor
☐ Information/advice by **text messages**
☐ Information/advice by **kp.org secure email**
☐ **Print materials** (e.g., brochures, tip sheets)
☐ Health **information/newsletters <u>by mail</u>**
☐ Health **information/newsletters <u>by email</u>**
☐ Get information from **Internet websites**
☐ Get information from **your doctor's home page**
☐ Watch **DVDs at home**
☐ Watch **online videos about health topics**
☐ Listen to **podcasts or online audio** programs
☐ Watch live **webinars or talks**
☐ **One-session** class, workshop or group **program**
☐ **Multi-session** class or group **program**
☐ **Online** interactive **program**
☐ Use a **health app** on your tablet or smartphone
☐ Join an **online chat room/online community**

Information Describing Who Participated in this Survey

59. What is your gender? ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Other

60. What is your date of birth? (***Year should not be 2020***) __ __ / __ __ / __ __ __ __
MONTH DAY YEAR

61. What describes your race and ethnicity? ***(Mark ALL that apply)***

☐ White or of European descent
☐ Middle Eastern/North African Arab
☐ African-American
☐ Other Black *(specify)*: _____
☐ Mexican or Central American ancestry
☐ Other Hispanic/Latino *(specify):* _____
☐ Filipino
☐ Chinese or Taiwanese
☐ Korean
☐ Japanese
☐ South Asian (Indian, Pakistani, Afghani, etc.)
☐ Southeast Asian *(specify)*: _____
☐ Iranian or Persian
☐ Other Asian *(specify):* _____
☐ Native Hawaiian or Pacific Islander
☐ Native American Indian or Alaska Native
☐ Other *(specify)*: _____

62. What is the highest level of school you completed? ***(Mark ONE only)***

☐ 8th grade or less *(primary or middle school)*
☐ 9th - 11th grade *(some high school)*
☐ 12th grade *(high school graduate or G.E.D.)*
☐ Technical/trade school certificate
☐ Some college *(no degree)*
☐ Associate's Degree *(e.g., AA, AS)*
☐ Bachelor's Degree *(e.g., BA)*, teaching credential
☐ Graduate or professional degree *(e.g., MA, MD)*

63 What is your current work status? ***(Mark ALL that apply)***

☐ Working for pay → **How many hours/week?** ___
☐ Self-employed → **How many hours/week**? ___
☐ Unemployed or laid off
☐ Unable to work due to health or a disability
☐ Retired
☐ Homemaker, parent, or unpaid caregiver
☐ Part-time or full-time student
☐ Do volunteer work at least once a week

64. Are you currently: *(Mark ONE only)*

☐ Married/living with partner ☐ In a committed relationship ☐ Separated ☐ Widowed ☐ Single or divorced

65. *(Optional)* Are you gay/lesbian or bisexual? ☐ No ☐ Yes, gay or lesbian ☐ Yes, bisexual

66. Which of the following best describes your total household (family) income from all sources in 2019, before taxes? ***(Mark ONE only)***

☐ Under $15,000
☐ $15,000 - $25,000
☐ $25,001 - $35,000
☐ $35,001 - $50,000
☐ $50,001 - $65,000
☐ $65,001 - $80,000
☐ $80,001 - $100,000
☐ $100,001 - $150,000
☐ More than $150,000

67. Which of the following best describes your current living situation? ***(Mark ONE only)***

☐ Live alone (or just with a pet) in your own home (house, apartment, condo, trailer, etc.)
☐ Live in a household with spouse/partner, family members, or non-relatives
☐ Live in a residence or community setting where meals, help, and social activities are available
☐ Temporarily staying with a relative or friend
☐ Other *(describe):* _____

68. When you are going someplace that is too far to walk, how do you usually get there? ***(Mark ALL that apply)***

☐ I drive myself
☐ Spouse or housemate drives me
☐ Family member or friend drives me
☐ Take a taxi or Uber/Lyft
☐ Take the bus or BART
☐ Use a ride service for seniors or people with disabilities
☐ Other *(specify):*_____

Thank you!