

2022

Weld County

COMMUNITY HEALTH SURVEY

Department of Public Health and Environment

SURVEY INSTRUCTIONS

Please have the **adult age 18 or older who has the next birthday** fill out this survey. Please complete the survey within the next 7 days to avoid additional mailings.

Please answer the questions only as they apply to you. Do not answer questions on behalf of other family members unless the question asks for that.

If you are not sure how to answer a question, please give the best answer and clearly write any comment you wish next to the question.

Answer the questions with clear markings. Use a ✓ or x. Otherwise, write in the answer as requested.

If you have questions or need assistance with the survey, please call our survey help line at (970) 400-2125.

Si desea llenar la encuesta en español, favor de llamar al (970) 400-2125 para recibir una encuesta por correo o vaya a healthsurvey.weldgov.com para llenarla en línea.

This survey is important. Your responses, along with others, will be grouped together to identify issues and concerns in Weld County related to health. We want to hear from you!

Your participation is voluntary. You may choose to participate or not. Your individual answers are kept confidential. Thank you for completing this survey!



Public Health

GENERAL HEALTH, HEALTH CARE ACCESS, AND HEALTH INSURANCE

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

2. **Please tell us a little more about your current health:**

Number of days

How many days during the past 30 days was your **physical health** (including physical illness or injuries) **not good**? _____ (0-30)

How many days during the past 30 days was your **mental health** (including stress, depression, or other emotional problems) **not good**? _____ (0-30)

During the past 30 days, how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation? _____ (0-30)

3. **Do you have one person you think of as your personal doctor or health care provider?**

Yes, only one Yes, more than one No Not sure

4. **During the PAST 12 MONTHS, did you delay or go without needed health care (include all medical care, dental care, mental health care, physical or occupational therapies)?**

Yes No → *If no, go to Question 5.*

4a. **If yes above, why did you not get all the health care you needed?** (Mark * or ✓ next to all that apply.)

- | | |
|---|--|
| <input type="checkbox"/> Cost too much | <input type="checkbox"/> No insurance |
| <input type="checkbox"/> Health problem not covered by insurance | <input type="checkbox"/> Couldn't take off work |
| <input type="checkbox"/> Couldn't find a provider who accepts my insurance (including Medicaid or Medicare) | <input type="checkbox"/> Transportation problems (didn't have a way to get to the appointment) |
| <input type="checkbox"/> No convenient time/couldn't get an appointment | <input type="checkbox"/> Couldn't find childcare |
| <input type="checkbox"/> Provider not available in my area/too far away | <input type="checkbox"/> COVID-19 pandemic |
| <input type="checkbox"/> Other: (Explain: _____) | |

5. **During the PAST 12 MONTHS, have you had an appointment with a doctor, nurse, or other health professional by video or phone? This is also known as telemedicine.**

Yes No → *If no, go to Question 6.* Not sure

5a. **If yes, what type of service or care did you get during your most recent telemedicine appointment?**

Choose one option below that best describes the service.

- Mental health
- Primary care (regular visit with a doctor, nurse practitioner, or physician assistant)
- Physical therapy/occupational therapy/speech therapy
- Specialist care (surgeons, heart doctors, allergy doctors, skin doctors, etc.)
- Substance use treatment
- Other: (Explain: _____)

6. **How likely are you to do the following?** (Mark * or ✓ for one answer in each row.)

	Extremely likely	Very likely	Somewhat likely	Not very likely at all	Not at all likely	Don't know
In the future, how likely are you to use telemedicine visits instead of in-person visits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

7. What is the primary source of your healthcare coverage? (Mark all that apply.)

- I do not have health insurance of any kind → *Go to Question 7a.*
- Health insurance through current or former employer (including Cobra) or union including a partner's or parent's plan (including retiree benefit)
- Health insurance plan that I, my parents, partner, or spouse purchase directly from an insurance company
- State-sponsored health plan through Colorado's marketplace/exchange
- Medicaid, also called Health First Colorado
- Medicare (for persons 65 years and older or with certain disabilities)
- Veteran's Affairs, Military Health, TRICARE, or CHAMPUS
- Other: (Please list: _____)

7a. Please indicate if any of the following are a reason that you do not have health insurance. (Mark ✕ or ✓ for one answer in each row.)

	Yes	No
Lost job/changed employers	<input type="radio"/>	<input type="radio"/>
A family member's job that provided coverage ended	<input type="radio"/>	<input type="radio"/>
Employer does not offer coverage or not eligible for employer coverage	<input type="radio"/>	<input type="radio"/>
No longer eligible due to age or income (under public insurance or parent's policy)	<input type="radio"/>	<input type="radio"/>
Disenrolled/dropped by Medicaid	<input type="radio"/>	<input type="radio"/>
Cost is too high	<input type="radio"/>	<input type="radio"/>
Don't need insurance because I am in good health	<input type="radio"/>	<input type="radio"/>
Don't know how to get insurance	<input type="radio"/>	<input type="radio"/>
Some other reason: (Describe: _____)	<input type="radio"/>	<input type="radio"/>

8. Do you currently have insurance that covers at least part of the cost for:

	Yes	No	Don't know
Prescription medicines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vision services?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. What is the one place you usually go when you are sick or need to see a medical professional?

(Mark ✕ or ✓ next to the one place you usually go.)

- I do not have a regular place for health care → *Go to Question 10.*
- Doctor's office, medical practice, or private clinic
- Community health clinic that offers a discounted fee (Sunrise, Salud, etc.)
- 24/7 Emergency room (Hospital-based or free-standing)
- Urgent care center or clinic that is inside a retail store
- School, college, or university clinic
- Veteran's Affairs, Military Health, TRICARE, or CHAMPUS
- Another place: (Describe: _____)

9a. Is this place (from Question 9) located in Weld County?

- Yes No Not sure

10. In the PAST 12 MONTHS:

Number of times

How many times did you go to your regular health care provider?

If none, enter "0"

10a. How many times did you receive care in a 24/7 emergency room?

If none, enter "0" and go to Question 11.

10b. If you received ER care in the past year, think of the most recent visit. Was that last ER visit for a condition that you thought could have been treated by a regular doctor if he/she had been available?

Yes

No

Not sure

11. Have you ever been told by a doctor or other health care professional that you had any of the following health conditions? (Mark * or ✓ for one answer in each row.)

	Yes	No
High blood pressure/hypertension	<input type="radio"/>	<input type="radio"/>
<i>If yes, are you currently taking blood pressure medication?</i>	<input type="radio"/>	<input type="radio"/>
Diabetes (high blood sugar) <i>(If you were told you had diabetes only during pregnancy, answer "no.")</i>	<input type="radio"/>	<input type="radio"/>
<i>If yes, are you currently taking diabetes medications, including insulin?</i>	<input type="radio"/>	<input type="radio"/>
Pre-diabetes (borderline diabetes)	<input type="radio"/>	<input type="radio"/>
High cholesterol	<input type="radio"/>	<input type="radio"/>
Heart attack, coronary artery disease, or stroke	<input type="radio"/>	<input type="radio"/>
Kidney disease (not kidney stones)	<input type="radio"/>	<input type="radio"/>
Skin cancer	<input type="radio"/>	<input type="radio"/>
Any other type of cancer	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>
Chronic Obstructive Pulmonary Disease (COPD), emphysema, or chronic bronchitis	<input type="radio"/>	<input type="radio"/>
Depression (major or minor)	<input type="radio"/>	<input type="radio"/>
Anxiety disorder	<input type="radio"/>	<input type="radio"/>
Arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	<input type="radio"/>	<input type="radio"/>
Other chronic condition: (Describe: _____)	<input type="radio"/>	<input type="radio"/>

12. Do you now have any of the following conditions? (Mark * or ✓ for one answer in each row.)

	Yes	No
Chronic pain (ongoing or re-occurring pain that persisted or progressed for more than 12 weeks)	<input type="radio"/>	<input type="radio"/>
<i>If yes, are you currently taking prescription pain medications?</i>	<input type="radio"/>	<input type="radio"/>
<i>If yes, are you currently using cannabis or CBD to manage pain?</i>	<input type="radio"/>	<input type="radio"/>
Depression, anxiety, or other mental health problem	<input type="radio"/>	<input type="radio"/>
<i>If yes, are you currently taking medicine from a doctor or other health professional for your condition?</i>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>

13. Has a doctor, nurse, or other health provider ever told you that you tested positive for COVID-19? (Include antibody/blood tests as well as nasal or throat swab tests.)

- Yes
- No → *If no, go to Question 14.*
- I prefer not to answer → *If prefer not to answer, go to Question 15.*
- Tested positive not using a health professional
- I think I had COVID-19 but did not get a test

13a. If yes, did you have any symptoms lasting 30 days or longer that you did not have prior to having COVID-19 (referred to as “long COVID-19”)? *Symptoms might include tiredness, difficulty concentrating or forgetfulness (sometimes referred to as “brain fog”), difficulty breathing, joint or muscle pain, fast-beating heart rate, dizziness on standing, depression, anxiety or mood changes, or symptoms that get worse after physical or mental activities.*

- Yes No Not sure

13b. If you tested positive for COVID-19, were you ever hospitalized for COVID-19?

- Yes No

14. If you got a COVID-19 test, did you get your most recent test from a doctor or a drive-through site or did you take one at home? *(If you did not get a test, skip this question.)*

- Test from a doctor Not able to get a test when I needed one
 Test from a drive-through site Other: _____
 Took a test at home

15. How difficult or easy do you find it to deal with unexpected problems that come up in your life? Use the scale from 1 to 10, where 1 means that you find it extremely easy to deal with unexpected problems, and 10 means you find it extremely difficult to deal with unexpected problems that come up. (Circle one number.)

1	2	3	4	5	6	7	8	9	10
Extremely easy					Extremely difficult				

16. What is your level of agreement with the following statement? (Mark * or ✓)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
When things go wrong in my life, it generally takes me a long time to get back to normal.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

PREVENTIVE HEALTH BEHAVIORS AND SCREENINGS

17. When was the last time you had the following? (Mark * or ✓ for one answer in each row.)

	Within the past year	Within the past 2 years	Within the past 3 years	Within the past 5 years	5 or more years ago	Never
Routine checkup by a doctor, nurse practitioner, or physician assistant (not for a specific illness, injury, or condition)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dental exam and/or teeth cleaning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood cholesterol test (by drawing blood or pricking your finger)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Blood sugar test (diabetes screening)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
WOMEN ONLY:						
Mammogram (breast x-ray)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pap smear (test for cervical cancer)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

WOMEN: If you had a hysterectomy, mark * or ✓ here →

18. What is your height (without shoes)?

	feet			inches
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19. How much do you weigh in pounds (without shoes)?

			pounds
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WOMEN: If currently pregnant, mark * or ✓ here →

20. How much do you agree with each of the following statements on vaccinations?

(Mark * or ✓ for one answer in each row.)

	Strongly agree	Agree	Disagree	Strongly disagree	No opinion
Vaccines are important for my health	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being vaccinated is important for the health of others in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vaccines are effective	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

21. Did you get a seasonal flu shot or nasal mist during this flu season (October 2021 - May 2022)?

Yes No Not sure

22. Did you get at least one dose of a COVID-19 vaccine?

Yes → If yes, go to Question 22a. No → If no, go to Question 22b and 22c. Not sure

22a. If yes, how many COVID-19 vaccines have you received?

1 – one 2 – two 3 – three

22b. If no, would you say you will or will not get vaccinated? If yes to Question 22, do not answer.

Definitely will	Probably will	Probably will not	Definitely will not	Not sure
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22c. If not vaccinated, what are your reason(s) for not getting the COVID-19 vaccine?

(Mark an * or ✓ next to all that apply.) If yes to Question 22, do not answer.

- | | |
|--|---|
| <input type="checkbox"/> Concerned about side effects or sickness | <input type="checkbox"/> Concerned about an allergic reaction |
| <input type="checkbox"/> Don't need or don't want a COVID-19 vaccine | <input type="checkbox"/> Not recommended by my health care provider |
| <input type="checkbox"/> Don't trust the government | <input type="checkbox"/> Don't trust COVID-19 vaccines |
| <input type="checkbox"/> Don't know where to go or who to call | <input type="checkbox"/> Other: (Describe: _____) |

HEALTH BEHAVIORS AND HABITS

23. Not counting juice, on average, how many servings of fruit do you eat each day? (A serving is ½ cup of chopped, cooked, canned, frozen fruit, or one small (tennis ball size) piece of fruit or ¼ cup of dried fruit.)

		Average number of servings per day (If none, enter "0.")
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24. On average, how many servings of vegetables do you eat each day? (A serving is ½ cup of chopped raw, cooked, canned, or frozen vegetables or 1 cup raw, leafy vegetables, or 4 ounces of 100% vegetable juice.)

		Average number of servings per day (If none, enter "0.")
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25. During the past month, other than your regular job, did you participate in any physical activities or exercise such as running, biking, golfing, gardening, or walking for exercise?

Yes No Not sure

26. **During the past 7 days, how many days did you walk quickly, do sports or other physical activity for 30 minutes or longer?** (Note: 30 minutes of activity does not have to be continuous.)

	Number of days (If none, enter "0.")
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27. **How often do you do the following when driving a car?** (Mark ✕ or ✓ for one answer in each row.)

	Always	Usually	Sometimes	Rarely	Never	Don't drive
Use your seatbelt	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Talk on the phone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Read/send email or text	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive within 2-3 hours after using marijuana	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drive within 1 hour after drinking alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

28. **In the PAST 30 DAYS, have you used or consume any of the following?** (Mark ✕ or ✓ for one answer in each row.)

	Yes, some days	Yes, every day	No
Regular cigarettes (excluding herbal or e-cigarettes)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chew/spit tobacco or other smokeless products such as snus or ZYN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cigars, cigarillos, or pipes including hookah	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E-cigarette or electronic vaping product that contains nicotine or can be filled with nicotine vaping juice/liquid	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marijuana/cannabis for medicinal purposes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Marijuana/cannabis for recreational purposes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

29. **Current marijuana/cannabis users only, otherwise go to next question: On the days you used marijuana, how many times per day did you use on average?**

		Average number of servings per day (0-99)	<input type="radio"/> None	<input type="radio"/> Not sure
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30. **Current alcohol users only, otherwise go to next question: Considering all types of alcoholic beverages, how many times during the PAST 30 DAYS did you have 4 or more drinks (for women) OR 5 or more drinks (for men) ON ONE OCCASION?** A drink is one 12-ounce can or bottle of beer, one 5-ounce glass of wine, or one shot of liquor. (If none, enter "0".)

		Number of times in PAST 30 DAYS you had 4 or more drinks (for women) or 5 or more drinks (for men) in one sitting (0-99)
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ENVIRONMENTAL HEALTH

31. **How much do you agree with each of the following statements about the city, town, or rural area where you live?** (Mark ✕ or ✓ for one answer in each row.)

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know
It is easy to walk in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy to bike in my community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is possible to get to many places I need to go by biking or walking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy for me to use public transit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
It is easy for me to carpool	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

32. **What is your level of concern with the following topics in Weld County?** (Mark **x** or **✓** for one answer in each row.)

	Very concerned	Moderately concerned	Neither concerned nor unconcerned	Moderately unconcerned	Very unconcerned	Don't know
Pollution from vehicles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pollution from agricultural operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pollution from oil and gas operations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Level of outdoor air quality	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potential rabies exposure for you, your family, pets, or livestock	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Exposure to radon in your home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Not enough sidewalks or trails for walking or biking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Disposal of household hazardous waste in landfills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

33. **When you want to know the status of air quality, is it easy for you to access information about it?**

Yes → *If yes, go to Question 34.* No → *If no, go to Question 33a.* Not sure

33a. **If no, why not? Explain:** _____

34. **If yes, where do you get information about air quality?** (Mark **x** or **✓** next to all that apply.)

- Social media / apps on my phone
- State or federal government websites
- News or weather forecasts (any media)
- Local or municipal sources including websites
- Other: _____

COMMUNITY-BASED SERVICE NEEDS

35. **Please indicate if any of the following apply to you currently.** (Mark **x** or **✓** for one answer in each row.)

	Yes	No
Are you dependent on medical equipment that requires electricity to maintain your health?	<input type="radio"/>	<input type="radio"/>
In the event of a disaster, would you need transportation provided by another person or service provider to evacuate to a safe location?	<input type="radio"/>	<input type="radio"/>
Do you require another person's assistance to maintain your health due to a chronic medical condition?	<input type="radio"/>	<input type="radio"/>
Can you safely get in and out of your home without help?	<input type="radio"/>	<input type="radio"/>

36. **In the PAST 12 MONTHS, did you think you needed mental health care or counseling services?**

Yes No → *If no, go to Question 37.*

36a. If yes, did you seek counseling or treatment?

- Yes → *If yes, where?* —————→ Private counselor, therapist, social worker, or other provider who specializes in mental health
 No → *If no, go to Question 36b.* Primary care doctor or nurse
 North Range Behavioral Health
 Church, temple, or other place of worship
 Other: _____

36b. If 36a is no, do any of these statements explain why you did not get treatment?

(Mark ✕ or ✓ for one answer in each row.)

	Yes	No
I was concerned that seeking treatment might cause family, friends, neighbors, and others to have a negative opinion of me	<input type="radio"/>	<input type="radio"/>
I was concerned that seeking treatment or counseling might have a negative effect on my job	<input type="radio"/>	<input type="radio"/>
My health insurance does not cover any or pay enough for mental health treatment or counseling	<input type="radio"/>	<input type="radio"/>
I couldn't afford the cost	<input type="radio"/>	<input type="radio"/>
I had a hard time getting an appointment	<input type="radio"/>	<input type="radio"/>
I did not know where to go to get services	<input type="radio"/>	<input type="radio"/>
I did not have time to seek treatment	<input type="radio"/>	<input type="radio"/>
Other reason: (_____)	<input type="radio"/>	<input type="radio"/>

37. In the PAST 12 MONTHS, did you or any member of your household need and/or use any of the community services listed below? (Mark ✕ or ✓ for one answer in each row.)

	Did not need	Needed and used	Needed but did not use	Don't know
Alcohol/substance use addiction counseling or treatment, including medications	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Low or no-cost dental/oral health services	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Assistance to sign up for health insurance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Services for an older adult/senior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mental health services (such as counseling or treatment for adults)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parenting information, training, or classes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Childcare/daycare financial assistance (including CCCAP)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Work-related/employment services (help finding work or job training)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Financial assistance (unemployment, Colorado Works/TANF, Social Security disability-SSI, Old Age Pension, Aid to Needy & Disabled), welfare, or disability payments	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Food or meal assistance (Food Bank, Food Stamps/SNAP, WIC, Meals on Wheels, School-based free or reduced lunch)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Housing services (rental/utility bill assistance, LEAP, or shelters)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Transportation assistance services (vouchers, reimbursements)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

HOUSEHOLD QUESTIONS

38. During the PAST 12 MONTHS, have you been living in stable housing that you own, rent, or stay in as part of a household?

Yes No

39. Are you worried or concerned that in the NEXT 2 MONTHS, you may not have stable housing? (i.e., that you own, rent, or stay in as part of a household)

Yes No

40. In the PAST 12 MONTHS, has anyone (family, friend, or other non-relative) stayed at your home on a temporary basis because of health issues, lack of or loss of housing, financial hardship, or similar reasons? (Mark * or ✓ for one answer in each row.)

	Yes	No
Health problem	<input type="radio"/>	<input type="radio"/>
Lack of or loss of housing	<input type="radio"/>	<input type="radio"/>
Financial hardship	<input type="radio"/>	<input type="radio"/>
Other: (Describe: _____)	<input type="radio"/>	<input type="radio"/>

41. CURRENTLY, does more than one family live in your home? (A family is a couple or parent/child group, so if household consists of a married couple and adult daughter and child, that is considered two family groups.)

Yes No

42. Do any of the problems listed below apply to your current housing situation? (Mark * or ✓ for one answer in each row.)

	Yes	No	Don't know
I pay more than 30% of my income in rent/mortgage and utilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The home I live in is in poor condition	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Too many people live in this home	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

43. How often in the PAST 12 MONTHS were you worried or stressed about: (Mark * or ✓ for one answer in each row.)

	Always	Usually	Sometimes	Rarely	Never
Having enough money to buy nutritious meals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paying your rent/mortgage?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Paying medical bills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Being able to afford the medical care you need?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Your health insurance becoming too expensive?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accessing or paying for childcare?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Getting COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Infecting someone else with COVID-19?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

44. What type of house do you live in currently?

- House
- Duplex or two-unit building
- Building/apartment with 3 or more units
- Mobile or manufactured home

INDIVIDUAL AND HOUSEHOLD INFORMATION

45. **How many times have you moved in the past year?**

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Number of times

46. **How long have you lived in Weld County?**

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Number of years

47. **Including yourself, how many people (adults and children) live in your household?**

		Number of adults age 18 and older
		Number of children age 17 and younger

48. **Do you rent or own your residence?**

- Own
- Rent
- Other arrangement

Explain:

49. **Do you or anyone in your household prefer to use a language other than English in the home?**

- No
- Yes → *What language?*

50. **What year were you born?**

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51. **Are you:**

- Female
- Male
- Transgender

52. **Do you consider yourself:**

- Heterosexual (straight)
- Lesbian or gay
- Bisexual
- Something else
- Unsure

53. **Are you of Hispanic, Latino/a, or Spanish origin?**

- Yes
- No
- Not sure

54. **Which one or more of the following would you say is your race?**

- White
- Alaska Native or American Indian
- Asian
- Black or African American
- Native Hawaiian or other Pacific Islander
- Other

55. **What is your current employment status?**
(Mark all that apply.)

- Employed full-time for wages
- Employed part-time for wages
- Self-employed
- Laid off or unemployed
- Furloughed/temporarily laid off
- Disabled or unable to work
- Full-time homemaker
- Full-time or part-time student
- Retired
- Military

56. **Do you work in Weld County?**

- No
- Yes

57. **What is the highest grade or year of school you have completed?**

- Less than 12th grade, no diploma
- High school diploma or GED
- Some college, no degree
- Associate's degree (e.g., AA, AS)
- Bachelor's degree (e.g., BA, AB, BS)
- Graduate or professional degree

58. **What was your household's total income before taxes in 2021?** *(Include income from all sources such as jobs, social security, public assistance, and retirement income for yourself and all other persons living in your household.) If you are a college student dependent on parental financial support, estimate your family's household income.*

- \$13,000 or less
- \$13,001 - \$22,000
- \$22,001 - \$25,000
- \$25,001 - \$32,000
- \$32,001 - \$34,000
- \$34,001 - \$43,000
- \$43,001 - \$52,000
- \$52,001 - \$60,000
- \$60,001 - \$70,000
- \$70,001 - \$88,000
- \$88,001 - \$125,000
- \$125,001 or more

59. What are the top three health concerns facing you, your family, and/or your community right now?

60. Finally, briefly describe how you and your household have been impacted by the COVID-19 pandemic.

Thank you for filling out this survey!