

SURVEY COVER SHEET COMPLETE ONE COVER SHEET ONLY

This Survey is a part of a fact-finding process. This information will be used for planning possible future initiatives. Tamir wishes to identify needs and gaps and to build on what already exists. The Survey is not intended to set expectations about new services that Tamir may provide in the near future

Please provide the following information on the Jewish adult or child that you are describing that has either a Developmental Disability, Dual Diagnosis (developmental disability and a chronic serious mental illness) or an Acquired Brain Injury.

Place a ✓ mark in the box following each question that best answers the question. For some questions there may be more than one answer or reason, so please mark all the answers or reasons that apply.

In order to ensure that we are not counting information on the same person more than once, please complete the information requested below. Put the initials and the birth date of the Jewish person(s) being described and include the Identification Number that is on the top of that person’s questionnaire. We will only use this information when contacting you if there is a need for follow-up.

Identification Number	Initials of person described	Birth date of the person described. Day/Month/Year

Although Tamir wishes to collect the information in the following box, your participation is voluntary. If you agree, please provide your name and telephone number, as we would like to be able to reach you if we need to collect more information. In addition, if you and/or your family are willing to participate in an interview, please indicate **Yes or No**.

Name	Address	☎ Number	Interview	
			YES	NO

If you are an agency staff, please include your name and telephone number as we may need to reach you for further information. _____ ☎ _____

If you have any questions about this Survey, please contact

1. Mark Palmer, Executive Director, Tamir Foundation, ☎ 725-3519, Fax 725-6045 for Developmental Disabilities and Dual Diagnosis questions or
2. Fran Hadley Consultant, HHAS ☎ 737-5226, Fax 737-5127 for Acquired Brain Injury questions.

**This Form To be Completed By The Family or Agency Staff
On Behalf of the Person Described**

1. How old are they				2. Is this person		Female	Male
0 - 9	10 - 17	18 - 29					
30 - 49	50 - 69	70 +					

3. What is their marital status	Single		Married or Common-law		Divorced or Widowed	
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4. Where do they live	By themselves		In a community group residence	
	With family		In an institution	
	With friends		Varies from time to time	

5. In what area do they live	Ottawa		Kanata		Vanier	
	Gloucester		Osgood		West Carleton	
	Goulbourn		Rideau			

6. Do they take part in any Jewish religious and/or cultural community activities	Yes		No		Don't Know	
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7. Is this person involved in any form of employment	Full-time paid		Supported or sheltered work	
	Part-time paid		Don't know	
	Volunteer			

Please provide some background as to why you have included this person in this survey. Remember that this does not need to be a professional assessment. This information is just to help us know a little about the person.

8. The person I have identified is a person with a

Developmental Disability		Acquired Brain Injury	
Dual Diagnosis (Development Disabilities and Chronic Serious Mental Illness)		Behavioural problem	
Physical disability		Other	

9. To the best of your knowledge, is this person	Independent (no regular support)	
	Mostly independent (an average of 2-5 support hours a week)	
	Partly independent (an average of 2-8 support hours a day)	
	Mostly dependent (an average of 9-23 support hours a day)	
	Dependent (24 hours support every day)	

10. In your opinion, what percent of this person's practical daily living needs(housing, transportation, health care) are being met				11. In your opinion, what percent of this person's Jewish religious and cultural needs are being met			
80-100%		20-49%		80-100%		20-49%	
50-79%		0-19%		50-79%		0-19%	

Please tell us what you know about the services they use now. (Remember: at this point we are just getting a basic outline of service use).

12. What type of service is used	Name of the organization providing the service (if you know)	13. How often is the service used			
		Daily	2-3x/wk	1x/wk	As needed
Day program	a.				
Residential care	b.				
Home support	c.				
Educational	d.				
Transportation	e.				
Recreational	f.				
Other	g.				

Please tell us something about the person caring (caregiver) for them now.

14. Who spends the most time caring for them

Parent		Professional	
Wife/husband		Child	
Sister/brother		Friend	
Volunteer			

15. How old is the caregiver

0 – 9		10 – 17		18 – 29	
30 – 49		50 – 69		70 +	

16. Is this caregiver

Female	Male

17. Is providing this support posing problems for the caregiver

Yes		No		Don't Know	
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18. Does this caregiver also have problems managing for themselves

Yes		No		Don't Know	
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19. Why

20. Are there others who help

Yes, regularly		Yes, occasionally		Yes, but seldom		Don't know		No	
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Thank you for completing this questionnaire.

Please return the survey in the stamped and self-addressed envelope.