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## INTRODUCTION

As part of a larger 2024-2025 Community Health Needs Assessment, RWJBarnabas Health System - in collaboration with our health coalition partners (Mercer, Middlesex, Somerset), St. Peter’s University Hospital, Capital Health, Lawrence Rehabilitation and Healthcare Center, local health centers, county and local health departments, and community organizations - is conducting a survey to learn more about the needs and strengths of the community and its residents. This information will be used to guide future services and programs and better coordination among organizations.

Filling out this survey is **voluntary**, and your responses are **confidential**. You will not be asked your name, address, or any other information that can identify you. This survey will take about 15 minutes to complete. Your input helps make sure that future plans meet different community and resident needs. If you have any questions or comments about this effort, please contact [BHPlanningDept@rwjbh.org](mailto:BHPlanningDept@rwjbh.org). Let’s shape the future of health for your community together!

## PART A: Background Information – You and Your Community

1. What is your zip code? \_\_\_\_\_ (Please write in the 5-digit number.)
2. What is your town or city? \_\_\_\_\_
3. How long have you lived in the area?
  - Under 1 year → If less than 1 year, what was the zip code of your previous address? \_\_\_\_\_
  - 1-4 years
  - 5-9 years
  - 10-19 years
  - 20+ years

**\*\*The following demographic questions are for analysis of this study only and are kept completely confidential.**

4. What year were you born? \_\_\_\_\_
5. How would you describe your ethnic or racial background? (Check all that apply).
  - Black or African American (e.g., African American, Haitian, Jamaican, Nigerian, Ethiopian)
  - Latino/a or Hispanic of Caribbean descent (e.g. Puerto Rican, Cuban, Dominican)
  - Latino/a or Hispanic of Mexican or Central or South American descent (e.g., Mexican, Salvadorian, Brazilian, Columbian)
  - East Asian (e.g., (e.g., Chinese, Japanese, Korean, Filipino, Vietnamese)
  - South Asian (e.g., (e.g., Indian, Pakistani, Bangladeshi, Nepalese)
  - Middle Eastern/North African/Arab (e.g., Egyptian, Moroccan, Jordanian, Syrian)
  - White/European American (e.g., German, Irish, English, Italian, Polish)
  - American Indian/Native American (e.g., Nanticoke Lenni-Lenape, Powhatan Renape, Ramapough)
  - Native Hawaiian or Other Pacific Islander (e.g. Hawaiian, Samoan)
  - Other (please specify): \_\_\_\_\_
  - Prefer not to answer
6. What is the highest level of education you have completed?
 

<input type="checkbox"/> Less than high school	<input type="checkbox"/> Associate or technical degree/certification
<input type="checkbox"/> Some high school	<input type="checkbox"/> College graduate
<input type="checkbox"/> High school graduate or GED	<input type="checkbox"/> Post-graduate or professional degree
<input type="checkbox"/> Some college	<input type="checkbox"/> Prefer not to answer

**Part B: Community Priorities, Assets, and Challenges**

**7. In your opinion, what are the TOP 3 HEALTH ISSUES OR CONCERNS in your community overall? (Please select only 3.)**

- Asthma
- Cancer
- Diabetes
- Heart disease
- Lung disease (e.g., COPD, emphysema)
- Overweight/obesity
- Aging-related health concerns (e.g., Alzheimer’s, falls)
- Mental health issues (e.g., depression, anxiety, suicide)
- Alcohol use, abuse, or overdose
- Smoking, vaping, or chewing tobacco
- Substance use, abuse, or overdose (e.g., opioids, heroin, misusing prescription drugs, marijuana)
- High stress lifestyle
- Infectious or contagious diseases (e.g., pneumonia, COVID, flu)
- Sexually transmitted infections (STIs) (e.g., Chlamydia, HIV/AIDS)
- Teen pregnancy
- Violence and community safety (e.g., gun violence, domestic abuse)
- Unintentional injuries (e.g., car accidents, drowning)
- Having enough health & social services that people can use
- Racism and discrimination
- Housing people can afford
- Hunger or having healthy food people can afford
- Adequate and quality education
- Poverty / job opportunities
- Other issue or concern not listed (specify):  
\_\_\_\_\_
- Don’t know

**8. In your opinion, what are the TOP 3 HEALTH ISSUES OR CONCERNS in your community for children and youth? (Please select only 3.)**

- Asthma
- Childhood cancers
- Diabetes
- Overweight/obesity
- Bullying
- Mental health issues (e.g., depression, anxiety, suicide)
- Alcohol use, abuse, or overdose
- Smoking, vaping, or chewing tobacco
- Substance use, abuse, or overdose (e.g., opioids, heroin, misusing prescription drugs, marijuana)
- High stress lifestyle
- Infectious or contagious diseases (e.g., pneumonia, COVID, flu)
- Sexually transmitted infections (STIs) (e.g., Chlamydia, HIV/AIDS)
- Teen pregnancy
- Child abuse and neglect
- Violence and community safety (e.g., gun violence, school violence, gangs)
- Unintentional injuries (e.g., car accidents, drowning)
- Having enough health & social services that children or youth can use
- Racism and discrimination
- Housing people can afford
- Hunger or having healthy food people can afford
- Adequate and quality education
- Poverty / job opportunities
- Other issue or concern not listed (specify):  
\_\_\_\_\_
- Don’t know

**9. Using the scale below, please indicate how much you agree (find the statement to be true) or disagree (find the statement to be false) with the following statements about the community. (Please pick only one choice per statement.)**

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don’t Know
<b>a. My community has safe outdoor places to walk and play.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>b. It's easy to live a healthy lifestyle in my community.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>c. My community is a good place to raise a family.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>d. There are educational opportunities for adults in my community.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>e. My community has places for everyone to socialize (e.g., library, churches, local clubs, senior meetings).</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>f. Schools in my community offer healthy food choices for children.</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>g. It would be easy for me to take public transportation to get to where I needed to go day-to-day (e.g., work, supermarket, doctor appointments, etc.).</b>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree	Don't Know
h. My community has transportation services for seniors and those with disabilities (e.g., to take to the supermarket, shopping centers, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. There are job opportunities in my area.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. If I needed help in feeding myself or my family, I would know which services to go to for help (e.g., food bank, food pantry, etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. There is enough housing that I can afford that is safe and well-kept in my community.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. In my neighborhood, there is not much violence, such as physical fights, gang activities, stealing, or assaults.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. In my community, there are few issues with violence between people, like abuse within families, mistreatment of the elderly, or bullying in-person or online.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. People in my community can afford basic needs like food, housing, and transportation.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Are you worried or concerned that in the next 2 months you may not have stable housing that you own, rent, or stay in as part of a household?

- Yes       No

11. How often are you unable to get to where you need to go because of not having a way to get there?

- Rarely or infrequently       About once a month       Once a week or more often  
 Several times a year       More than once a month

12. Please read the following statements that people have made about their food situation. For each one, choose how true the statement was for your household over the last 12 months.

	Often True	Sometimes True	Never True
a. We worried whether our food would run out before we got money to buy more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. The food that we bought just didn't last and we didn't have money to get more.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. We rely on a community supper program, food pantry, or meal assistance program to supplement our household.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. In the past 12 months, have you received free or low-cost assistance from an organization or government program to help you with any of the following? (Please check all that apply.)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Transportation    | <input type="checkbox"/> Childcare                    | <input type="checkbox"/> Immigration issues              |
| <input type="checkbox"/> Utility Bills     | <input type="checkbox"/> Housing                      | <input type="checkbox"/> Legal Issues                    |
| <input type="checkbox"/> Education         | <input type="checkbox"/> Job search or training       | <input type="checkbox"/> Have not received assistance    |
| <input type="checkbox"/> Food (e.g., SNAP) | <input type="checkbox"/> Care for seniors or disabled | <input type="checkbox"/> Prefer not to answer/Don't know |
| <input type="checkbox"/> Medications       | <input type="checkbox"/> Translation/interpretation   |  |

### PART C: Health Status & Conditions

14. How would you describe your overall health?

- Excellent       Very good       Good       Fair       Poor

**15. Have you ever been told by a doctor or other health professional that you have had any of the following?**

**For each "Yes" in question 15a, please answer in 15b:** Are you currently under care for this condition?

**\*Reminder: Filling out this survey is voluntary, and your responses are confidential. You will not be asked your name, address, or any other information that can identify you.**

	15a. Ever been told by a provider you have....?		15b. If yes, currently under medical care?	
	Yes	No	Yes	No
Heart condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer (any type)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease (e.g., COPD, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alzheimer's or dementia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing problem	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression or anxiety issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance abuse issues (drug or alcohol)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Addiction to smoking or vaping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**16. Please select if any of the following reasons keep you from eating foods that are part of a healthy diet. (Check all that apply.)**

- Lack of time to buy or prepare healthy meals
- Transportation to getting healthy foods
- Don't always know what foods are part of a healthy diet
- Don't know how to buy or prepare healthy foods
- Price of healthy foods / healthy foods cost too much money
- Physical disability to buying or preparing healthy foods
- Lack of equipment (e.g., working stove, pots) to prepare food
- Don't like the taste or healthy foods don't fill me up
- Not in the mood for healthy foods
- Other (please specify): \_\_\_\_\_
- Nothing keeps me from eating healthy foods

**17. During the past month, other than your regular job, did you participate in any physical activities or exercises such as walking, running, biking, dancing, sports, or other similar activity?**

- Yes
- No
- Prefer not to answer

**18. Do you have any children under age 18 that live with you at home or who you have regular responsibility for?**

- Yes → **18a. If yes, during the past 7 days, on how many days was your child physically active for a total of at least 60 minutes per day? (Specify a number 0-7): If you have more than 1 child, please complete for up to 3 children.**
- No

Child 1: \_\_\_\_\_ Child 2: \_\_\_\_\_ Child 3: \_\_\_\_\_

**19. Have you participated in any of the following screenings, services, or programs in the past 2 years?**

	Yes	No	Don't know
Annual physical exam or check-up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental screening or check-up (e.g., x-rays, cleaning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any form of mental health counseling (e.g., for depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any form of alcohol or drug/substance use counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stop smoking/ vaping program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any form of nutrition education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any form of heart disease education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parenting classes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Flu shot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
COVID shot or booster	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cholesterol screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes screening or blood sugar check	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hearing screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram or breast examination/screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer screening (e.g., colonoscopy, fecal occult blood test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**PART D: Healthcare Access & Barriers to Care**

**20. What type of health insurance do you have?**

- Medicare
- Medicaid/NJ FamilyCare
- Private/health insurance that you and/or your employer pay for (e.g., Aetna, Humana, Blue Cross Blue Shield, etc.)
- Some other type of health insurance (*specify:*) \_\_\_\_\_
- No health insurance
- Prefer not to answer

**21. Over the past 2 years, which, if any, of these issues made it hard for you or a household family member to get medical treatment or care when needed? (Check “yes” if issue made it hard/was a problem for you or your family and “no” if issue did not make it hard to get medical treatment or care or was not a problem.)**

**\*Reminder: Filling out this survey is voluntary, and your responses are confidential. You will not be asked your name, address, or any other information that can identify you.**

	Yes	No	Don't know
Insurance problems (e.g., doctors do not take your insurance, you do not have any insurance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of care (e.g., you were unable to pay, co-pays too high)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doctors not accepting new patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wait times at doctor's office or clinic are too long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard to schedule an appointment at a convenient time of day/evening/weekend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear or dislike of doctors or hospitals; unfriendly doctors, providers, or office staff; do not feel welcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't get time off to get care - will not get paid or will lose job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unable to find care; do not know where to go to for care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language problems (e.g., hard to talk with health provider or office staff)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services not accessible for people with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health information not kept confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afraid due to immigration status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some other issue that kept you/household family member from getting medical treatment or care ( <i>specify:</i> ) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**22. When trying to get medical care, how often have you PERSONALLY felt discriminated against based on any of the following characteristics:**

	Frequently	Sometimes	Never
Race or ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cultural or religious background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language or speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Income level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Body size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gender or gender identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical or mental disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**23. If you had a question or needed information about improving your health, where would you go for advice? (Check all that apply.)**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Faith based organization | <input type="checkbox"/> Health care provider (e.g., physician, nurse practitioner) | <input type="checkbox"/> Social media resources (e.g., Facebook) |
| <input type="checkbox"/> Family member            | <input type="checkbox"/> Hospital emergency department                              | <input type="checkbox"/> Urgent care                             |
| <input type="checkbox"/> Free clinic              | <input type="checkbox"/> Local health department                                    | <input type="checkbox"/> There is no good source for me          |
| <input type="checkbox"/> Friends                  | <input type="checkbox"/> Online resources (e.g., WebMD)                             |  |

**24. In the past 2 years, was there ever a time when you needed to see a health care provider or specialist but could not because of availability, cost, or insurance problems?**

**For each "Yes" in question 24a please indicate in question 24b what prevented you from seeing a provider or specialist?**

	Q24a. Needed specialist but could not go because of issues in Q24b.		Q24b. (If Yes) What prevented you from seeing a provider or specialist? (check all that apply)			
	Yes	No	Provider availability	Cost	Insurance problems	Other (write in)
Behavioral health (e.g. individual or group counseling, mental health services, substance use disorder, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Children's health or pediatrics (e.g. infant care, well-child check-ups, immunizations, school or sports physicals, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer (e.g. cancer screenings, radiation, chemotherapy, cancer survivorship)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart health/cardiovascular issues (e.g. coronary artery disease, heart attack, high blood pressure, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emergency/hospital care (e.g. sudden or serious illness, medical emergencies, rehabilitation, inpatient care)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Issues with brain, spinal cord, or nerves/Neurology (e.g. Alzheimer's, epilepsy, MS, stroke, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bone and muscle issues/Orthopedics (e.g., breaks and fractures, arthritis, dislocated joints, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Women's health (e.g. family planning, gynecology, pregnancy care, menopause, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (Specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

**PART E: Mental Health & Substance Use**

**25. Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?**

(Please specify a number between 0 to 30): \_\_\_\_\_

**26. During the past 30 days, for about how many days did poor mental health keep you from doing your usual activities, such as self-care, work, or recreation?**

(Please specify a number between 0 to 30): \_\_\_\_\_

27. In the last two years, was there a time when you or someone in your household needed help for mental health problems, such as **feeling very sad, anxious, or other emotional concerns**, but couldn't get the needed care?

- Yes, I/my family member needed mental health services and/or treatment but could not get them
- No, I/my family member needed mental health services and/or treatment and was able to get them
- No, I/my family member did not need mental health services and/or treatment
- Prefer not to answer/don't know

28. In the last two years, was there a time when you or someone in your household needed help for **problems with using drugs or alcohol**, but couldn't get the needed support?

- Yes, I/my family member needed substance use services and/or treatment but could not get them
- No, I/my family member needed substance use services and/or treatment and was able to get them
- No, I/my family member did not need substance use services and/or treatment
- Prefer not to answer/don't know

***If you or a household family member did not need mental health or substance use services in the past 2 years, please skip to Part F, question 30.***

29. Over the past 2 years, which, if any, of these issues made it hard for you or a household family member to get mental health or substance use services and/or treatment when needed? (Check "yes" if issue made it hard/was a problem for you or your family and "no" if did not make it hard or was not a problem.)

	Yes	No	Don't know
Insurance problems (e.g., doctors do not take your insurance, you do not have any insurance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cost of care (e.g., you were unable to pay)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counselors or services not accepting new patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wait times are too long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear or dislike of providers, counselors, doctors or hospitals; unfriendly doctors, providers, or office staff; do not feel welcome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Can't get time off to get care - will not get paid or will lose job	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Language problems (e.g., hard to talk with health provider or office staff)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services not accessible for people with disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Childcare problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health information not kept confidential	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Afraid due to immigration status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stigma / shame about getting these types of services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear of being hospitalized against my will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fear that my work/employer might find out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Some other issue that kept you/household family member from getting treatment or care (specify:)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**If you or someone you care about needs help, please see the resources below:**

**New Jersey Hopeline** - for confidential support to anyone in emotional distress or suicidal crisis. **Text or Call at 988**

**ReachNJ** - for help with a substance use disorder. **Call 844-732-2465**

**PART F: In Your Own Words**

30. Use the space below to expand on a topic previously mentioned or an important health-related topic that was not mentioned in this survey that you believe is important for when planning health and community services.

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**PART G: Additional Background Information**

**\*\*The following demographic questions are for analysis of this study only and are kept completely confidential.**

**31. Which most closely describes your gender?**

- Woman
- Man
- Transgender woman
- Transgender man
- Non-binary/gender queer (neither exclusively male or female)
- Agender/I don't identify with any gender
- Additional gender category (please specify): \_\_\_\_\_
- Prefer not to answer

**32. Which most closely describes your sexual orientation?**

- Straight or heterosexual
- Gay or lesbian
- Bisexual, pansexual, or queer
- Asexual
- I am not sure
- Additional category (please specify): \_\_\_\_\_
- Prefer not to answer

**33. Which most closely describes your annual household income before taxes? *Household income is the total money earned by everyone living in your home in the past year (e.g., income earned, alimony received, etc.).***

- Less than \$10,000
- \$10,000 to \$14,999
- \$15,000 to \$24,999
- \$25,000 to \$34,999
- \$35,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,000 to \$149,999
- \$150,000 to \$199,999
- \$200,000 or more
- Prefer not to answer

**34. Which of the following best describes your marital status?**

- Single
- Separated/divorced/widowed
- Married
- Domestic partnership/civil union/living together
- Prefer not to answer

**35. Were you born in the United States?**

- Yes (please skip to question 36)
- No (please answer question 35a) →
- Prefer not to answer

**35a. If no, how long have you lived in this country?**

- Under 1 year
- 1-4 years
- 5-9 years
- 10 years or more, but not my whole life
- I have lived in the U.S. nearly my whole life
- Prefer not to answer

**36. What is the primary language(s) spoken in your home? (Please check all that apply.)**

- English
- Spanish
- Portuguese
- Hindi
- Gujarati
- Mandarin
- Cantonese
- Korean
- Arabic
- Tagalog
- Italian
- Polish
- Haitian Creole
- Yiddish
- Other: \_\_\_\_\_
- Prefer not to answer

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***This concludes our survey. Thank you for your time. We greatly appreciate your participation.***