



Child Care Community Assessment

The purpose of this survey is to better understand what families need in order to improve and add to our Child Care services. Your feedback is very important and will be kept confidential. Thank you for taking the time to answer these questions. ***Please fill out only one survey per family.***

Tell Us about Yourself

- What category best describes you?

<input type="checkbox"/> Parent working in the home	<input type="checkbox"/> Foster parent	<input type="checkbox"/> Teen parent working
<input type="checkbox"/> Parent working outside of home	<input type="checkbox"/> Grandparent/Guardian	<input type="checkbox"/> Teen parent in school
<input type="checkbox"/> Parent in school	<input type="checkbox"/> Single parent	<input type="checkbox"/> Other _____
- Your gender/sex:

<input type="checkbox"/> Male	<input type="checkbox"/> Female
-------------------------------	---------------------------------
- Your age:

<input type="checkbox"/> 15 and under	<input type="checkbox"/> 16-21	<input type="checkbox"/> 22-27
<input type="checkbox"/> 28-33	<input type="checkbox"/> 34-39	<input type="checkbox"/> 40-45
<input type="checkbox"/> 46-51	<input type="checkbox"/> 52-59	<input type="checkbox"/> 60 and over
- Your ethnicity/race:

<input type="checkbox"/> Mohawk/Other Six Nations	<input type="checkbox"/> Alaskan	<input type="checkbox"/> African-American
<input type="checkbox"/> Asian/Pacific Islander	<input type="checkbox"/> White/Anglo Caucasian	<input type="checkbox"/> Hispanic
<input type="checkbox"/> Other _____		
- What is the primary language spoken in your home?

<input type="checkbox"/> English
<input type="checkbox"/> Mohawk
<input type="checkbox"/> Other _____
- How important is spirituality in the lives of your child, yourself and family.

- Describe the traditional practices used in your family.

Tell Us about Your Family

- What is your marital status?

<input type="checkbox"/> Single	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
<input type="checkbox"/> Separated	<input type="checkbox"/> Living with my partner	<input type="checkbox"/> Widowed
<input type="checkbox"/> Other _____		
- Which of the following best describes your family? [Check only one]

<input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Single female head of household
<input type="checkbox"/> Single male head of household	<input type="checkbox"/> Other _____



10. How many family members reside in your home? _____
11. How many adults, including yourself, live in your household? _____
12. Which category best represents the age of the head of household? [Check only one]
- 18-24 25-34 35-44
 45-54 55-64 65 or older
13. How many children live with you? (under 18 years old) _____
14. How old is each child?

	Child #1	Child #2	Child #3	Child #4	Child #5
0 to 2 years old					
3 to 5 years old					
6 to 13 years old					
14 to 17 years old					

Tell Us about Your Family's Home

15. List the community that you live in _____
16. If you currently live off the Akwesasne reserve, how many miles away from the reserve are you? _____
17. Are you currently homeless?
 Yes No
18. Have you ever been homeless?
 Yes No
- If so, for how long? _____
19. About your home, does your family
 Rent Live with other people Own
 Other _____
20. What type of home do you have?
 Adobe/Stone HUD/Manufactured Trailer
 Other _____
21. About your living situation, does your family live
 Alone as a family With relatives With friends
 In a shelter Other _____
22. How often are these statements true about your housing?
Our housing is...
- | | Never
True | Sometimes
True | Often
True | Always
True |
|------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Just the right size | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Crowded | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Needs major repairs | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Old and aged | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Kept in good condition | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
23. Does your home have adequate plumbing?
 Yes No



Tell Us about Your Family's Health Care

24. What type of health insurance do you have?
 None Medicaid Provided through work
 Private

If not insured, what are the main reasons why? [Check all that apply]
 Don't know how or where to get it Job doesn't provide it Don't need it
 Can't afford it Don't qualify for it Other _____

If you do not have insurance, are you eligible for Medicaid?
 No Yes Don't know

25. What type of insurance do(es) your child(ren) have?
 Same insurance Not insured Other

If not insured, what are the main reasons why? [Check all that apply]
 Don't know how or where to get it Job doesn't provide it Don't need it
 Can't afford it Don't qualify for it Other _____

26. Where do you usually take your child to get medical care? [Check all that apply]
 Family doctor Community health clinic Emergency room
 Family dentist IHS Other _____

27. What type of dental insurance do you have?
 None Medicaid Provided through work
 Private

28. What type of dental insurance do(es) your child(ren) have?
 Same insurance Not insured Other

Tell Us about Your Transportation

29. How does your child get to child care?
 Personal car Bus Look for a ride Other _____

30. Is your family in need of transportation?
 Yes No

Tell Us about Your Employment

31. Are you currently employed?

<i>You</i>		<i>Spouse</i>
<input type="checkbox"/>	Not employed	<input type="checkbox"/>
<input type="checkbox"/>	Employed, full-time	<input type="checkbox"/>
<input type="checkbox"/>	Employed, part-time	<input type="checkbox"/>
<input type="checkbox"/>	Self employed	<input type="checkbox"/>

If not, what keeps you from employment?



- Lack of child care
- No transportation
- Lack of skills
- Fear of losing public assistance
- In school
- Other _____

32. Are other adult members in your family employed?[Check one for each if applicable]

- | | | |
|--------------------------|---------------------|--------------------------|
| <i>Member 1</i> | | <i>Member 2</i> |
| <input type="checkbox"/> | Not employed | <input type="checkbox"/> |
| <input type="checkbox"/> | Employed, full-time | <input type="checkbox"/> |
| <input type="checkbox"/> | Employed, part-time | <input type="checkbox"/> |
| <input type="checkbox"/> | Self employed | <input type="checkbox"/> |

Tell Us about Your Income

33. What is your annual household income?

- | | | |
|--|--|--|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$10,000 - \$14,999 | <input type="checkbox"/> \$15,000 - \$24,999 |
| <input type="checkbox"/> \$25,000 - \$34,999 | <input type="checkbox"/> \$35,000 - \$44,999 | <input type="checkbox"/> \$45,000 - \$54,999 |
| <input type="checkbox"/> \$55,000 - \$64,999 | <input type="checkbox"/> \$65,000 and over | |

34. In what industry is the major wage earner in your home employed? [Circle number]

1. Agriculture
2. Construction
3. Manufacturing
4. Retail/Wholesale
5. Transportation, Communications, and Public Utilities
6. Finance, Insurance, Real Estate
7. Government (Includes Education)
8. Services (Includes Retail)
9. Retired
10. Homemaker
11. Craftsperson

35. Are you entitled to receive child support or alimony?

- | | | |
|-----------------------------|---|---------------------------------------|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, child support | <input type="checkbox"/> Yes, alimony |
|-----------------------------|---|---------------------------------------|

36. Do you receive your child support or alimony?

- | | | |
|--|--|---|
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, but rarely | <input type="checkbox"/> Yes, sometimes |
| <input type="checkbox"/> Yes, most of the time | <input type="checkbox"/> Yes, always | |

37. Do you receive Public Assistance?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

If so, Please Indicate.

- | | | |
|--------------------------------------|---|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> TANF | <input type="checkbox"/> Social Security |
| <input type="checkbox"/> Food Stamps | <input type="checkbox"/> Commodities | <input type="checkbox"/> SSI |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Workers Compensation | <input type="checkbox"/> Unemployment Benefits |
| <input type="checkbox"/> Other _____ | | |

Tell Us about Your Child Care Needs

38. Do you need child care for your children on a regular basis?

- | | |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

If so, please indicate the number of children in each age range in need of child care



- Infant (Birth to 11 months)
- Toddler (11 to 36 months)
- Preschool (3 to 5 years)
- After School Care (K-6th grade)
- After School Care (7-9th grade)

39. Are you currently using child care services?
 Yes No

If so, what type of child care you are utilizing? [Check all that apply]

- Full Time
- Half Days (5 days a week)
- Partial Week (2 or 3 times/week)
- Half Days-Partial week (2 or 3 times/week)
- After-School Care
- Night Care or Evening Care

40. Please check one in each column for the type of care you USE and the type of care you PREFER.

	Type of Care I Use	Type of Care I Would Prefer
Care by parent in own home	<input type="checkbox"/>	<input type="checkbox"/>
Care by a relative in their home	<input type="checkbox"/>	<input type="checkbox"/>
Care by a relative in own home	<input type="checkbox"/>	<input type="checkbox"/>
Care by non-relative in own home	<input type="checkbox"/>	<input type="checkbox"/>
Care by a non-relative in their home	<input type="checkbox"/>	<input type="checkbox"/>
Child care center	<input type="checkbox"/>	<input type="checkbox"/>

41. What is the reason for your decision about the child care arrangement you currently have?
 Cost was affordable Location near home or work My child would be safe
 Program has accreditation Got a referral from family or friend Other _____

42. About how many hours per week is your child in child care? _____

43. Please check the time frames that child care is most needed during the week? [Check only one]
 Mornings only (6-9 a.m.) Evenings only (5-6 p.m.) Weekends
 Afternoons only (2-5 p.m.) Highly varying hours and days (8-5 p.m.)

44. How difficult is it for you to arrange back-up child care?
 Very difficult Somewhat difficult Not at all difficult

45. How difficult is it for you to find child care in the summer months?
 Very difficult Somewhat difficult Not at all difficult

46. Are you currently expecting a child?
 Yes No

47. Would you like to have Early Head Start services at home for children from birth to age three?
 Yes No

Tell Us about Your Education

48. Indicate the highest level of education completed by household

<i>Yourself</i>		<i>Spouse/Partner</i>	<i>Other Adult</i>
<input type="checkbox"/>	Some high school	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	High School graduate	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>



- Vocational school
- Some College
- AA degree (2 year degree)
- Bachelor's degree
- Some graduate school
- Master's Degree

49. Are you, your spouse/partner or other household member currently in school?

- | | | | |
|--------------------------|----------------|--------------------------|--------------------------|
| <i>Yourself</i> | | <i>Spouse/Partner</i> | <i>Other Adult</i> |
| <input type="checkbox"/> | No | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Yes, full-time | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Yes, part-time | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

50. If you, your spouse/partner or other household member are in school, what type of school?

- | | | | |
|--------------------------|-------------------|--------------------------|--------------------------|
| <i>Yourself</i> | | <i>Spouse/Partner</i> | <i>Other Adult</i> |
| <input type="checkbox"/> | Working on GED | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Vocational School | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | College | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Other | <input type="checkbox"/> | <input type="checkbox"/> |

51. If you are not in school, do you, your spouse/partner or household member want to attend school in the future?

- | | | | |
|--------------------------|-----|--------------------------|--------------------------|
| <i>Yourself</i> | | <i>Spouse/Partner</i> | <i>Other Adult</i> |
| <input type="checkbox"/> | No | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Yes | <input type="checkbox"/> | <input type="checkbox"/> |

If No, explain why? _____

Tell Us about Services in Your Community

52. What barriers prevent families from getting needed services? [Check only what applies to you and your family]

- | | | |
|---|---|--|
| <input type="checkbox"/> Not aware of existing services | <input type="checkbox"/> Services are too far from home | <input type="checkbox"/> Waiting list are too long |
| <input type="checkbox"/> Agencies not open at convenient time | <input type="checkbox"/> Child care is not available | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Agency fees are too high | <input type="checkbox"/> Rules & eligibility | <input type="checkbox"/> Agency staff are rude |
| <input type="checkbox"/> Concerns about confidentiality | <input type="checkbox"/> Uncomfortable with "outsiders" | <input type="checkbox"/> None |

53. Indicate if your family has any of the following needs

- | | | |
|---|--|--|
| <input type="checkbox"/> Education | <input type="checkbox"/> Employment services | <input type="checkbox"/> Food and nutrition help |
| <input type="checkbox"/> Health-related or medical help | <input type="checkbox"/> Budgeting or stretching income | <input type="checkbox"/> Housing improvements |
| <input type="checkbox"/> Resources in community | <input type="checkbox"/> Emergency rent, utility or shelter help | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Child Care | | |

54. Who or where do you turn for assistance most often?

- | | | |
|--|--|--------------------------------------|
| <input type="checkbox"/> Church | <input type="checkbox"/> Health clinic | <input type="checkbox"/> Friend |
| <input type="checkbox"/> Teacher | <input type="checkbox"/> Family member | <input type="checkbox"/> Co-worker |
| <input type="checkbox"/> Child care center | <input type="checkbox"/> Social services | <input type="checkbox"/> Other _____ |

55. Which Community Service do you receive and how adequate are they

Use		Don't Know	Not Available	Poor	Good	Excellent
	Child Care					



<input type="checkbox"/>	Community & Church organizations					
<input type="checkbox"/>	Crisis Intervention & Counseling (BHS)					
<input type="checkbox"/>	Education & Literacy(JOM/Library)					
<input type="checkbox"/>	Employment & Training (WIA)					
<input type="checkbox"/>	Mental Health Services(BHS/IHS)					
<input type="checkbox"/>	Substance Abuse Treatment (BHS/IHS/Cottonwood)					
<input type="checkbox"/>	Emergency Assistance (EMS/Fire Dept.)					
<input type="checkbox"/>	Child Welfare & Foster Care (ISS)					
<input type="checkbox"/>	Law Enforcement					
<input type="checkbox"/>	Culture (Historic Preservation/Language Pres.)					
<input type="checkbox"/>	Transportation (CHR)					
<input type="checkbox"/>	Family Support Services (VOCA/BHS)					
<input type="checkbox"/>	Health (Diabetes Program)					
<input type="checkbox"/>	Public Health Services (IHS)					
<input type="checkbox"/>	Roads Maintenance (POI Roads Dept.)					
<input type="checkbox"/>	Housing Needs (PIHA)					
<input type="checkbox"/>	Solid Waste Management					
<input type="checkbox"/>	Legal aid (Courts/POI Legal Serv.)					
<input type="checkbox"/>	Youth – Isleta Boys and Girls Youth Sports					

Tell us about your Special Needs

56. Do you have a child with special needs?
 Yes No

How old is this child? _____

57. Have you ever been involved in the referral process (e.g. referral meeting, permission, consent, etc.)?
 Yes No

58. What type of disability or special need does your child have?
 Speech and Language Mental Retardation Non Categorical/Dev. Delay
 Autism Hearing Impairment Learning Disabilities
 Health Impairment Visual Impairment Multiple Disabilities

59. Where does your child receive services?
 NAPPR APS LLPS
 Head Start Other _____

60. If your child is receiving therapy services, would you like those services to continue throughout the summer?
 Yes No

61. Which services is your child receiving?
 Occupational Therapy Behavioral/Mental Health Other _____
 Physical Therapy Speech and Language

Tell Us How We Are Doing

62. How did you hear about ECDP child care?
 Friends/Relatives Child Care flyer or brochure SRMT Website
 Child Care Staff Newspaper Other _____



Office of Child Care



63. Have you volunteered in the child care program?
 Yes No

If yes, please check all of the ways you have volunteered?

- Helping in the classroom Helping with field trips Helping on the bus
 Community Action Team (CAT) Helping with cooking Special Projects
 Other _____

If yes, how would you rate your experience?

- Very good Good
 Needs Improvement Unacceptable

If no, why haven't you volunteered? _____

64. To help us plan for the future would you please tell us what program would best fit your needs?

- The current program option; 5 days per week; 7:30 am – 5 pm; year round
 Home based program with 1 home visit a week
 Full day program; 5 days per week; 9 months a year
 Part day program; 3 days a week; year round
 Early Head Start (Infants and Toddlers)
 Summer months; Five days per week; Full day

Please rate your experience in child care:

Please Check One:	Very Good	Good	Needs Improvement	Unacceptable
How understandable was the orientation you received to participate in the child care program?				
How understandable are the application forms?				
How well do you think the staff answer your questions?				
How adequate is the number of contacts with staff?				
How comfortable are you speaking with staff?				
How well are staff meeting your family's needs?				
How well do you think staff are at doing what they say they will do?				
How well do you think child care is doing in assisting in your child's education?				
How well are you treated by staff?				
How well do you think staff respect your opinions, ideas, and concerns?				
How prompt are actions taken by staff to deliver services?				
How well do you think staff know you and your family?				



Office of Child Care



How would you rate the individualized attention your family receives from the child care program?				
Overall, how would you rate your child's experience in the classroom?				
Overall, how would you rate your experience in the child care program?				

65. What areas of the child care program do you feel could use improvement? (Check all that apply)

- | | | |
|--|--|---|
| <input type="checkbox"/> Education/Literacy | <input type="checkbox"/> Nutrition & Meal Service | <input type="checkbox"/> Transportation |
| <input type="checkbox"/> Health Assessment/Follow-up | <input type="checkbox"/> Disabilities Assessment/Follow-up | <input type="checkbox"/> Culture |
| <input type="checkbox"/> Family/Community Partnerships | <input type="checkbox"/> Classroom environment | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Curriculum | <input type="checkbox"/> Communication | |

66. Please list suggested improvements for the program.

Tell Us about Your Training Interest

67. Please specify your interest level in attending the following training classes or workshops.

- | | |
|--|---|
| <input type="checkbox"/> Child Abuse & Neglect | <input type="checkbox"/> Money management |
| <input type="checkbox"/> Child Growth & Development | <input type="checkbox"/> Nutrition |
| <input type="checkbox"/> Computer training | <input type="checkbox"/> Parenting Skills |
| <input type="checkbox"/> Continuing Education Training | <input type="checkbox"/> Technical or Vocational Training |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Self-esteem |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Employment Training | <input type="checkbox"/> Challenging Behavior |
| <input type="checkbox"/> First Aid | <input type="checkbox"/> Stress Management |
| <input type="checkbox"/> Food Preparation | <input type="checkbox"/> Health, Wellness & Hygiene |
| <input type="checkbox"/> Income Tax Filing | <input type="checkbox"/> Other _____ |