



**COUNTY OF ORANGE
HEALTH CARE AGENCY**

**PUBLIC HEALTH SERVICES
DISEASE CONTROL & EPIDEMIOLOGY**



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March 15, 2013

Dear Client,

The HIV Planning Council and Orange County Health Care Agency are conducting a client survey. We hope you will help us by taking a few minutes to fill out the short survey.

This survey will help the Planning Council understand your thoughts on how we can better plan for HIV services in our community. This survey will ask about your experiences in getting services in Orange County and any problems you may have had in trying to get these services. Your input is very important in helping us make decisions about medical and supportive services for our county. Completing this survey is by choice and it will not affect the services you have been receiving.

Here are some guidelines for the survey:

- **Anonymous and confidential.** Please do not write your name on this survey.
- **Disponible en español.** Please ask your case manager for a Spanish version if you would prefer.
- **Please complete only one survey.** If you receive a survey from more than one agency, please complete only one. If you complete a paper survey, please do not also complete an online survey.
- **April 30, 2013 Deadline.** Please return the survey by April 30, 2013. Surveys returned after the deadline will be read, but may not be used for our planning process.

You can submit the survey in **ONE** of three ways:

- 1) Complete the survey online at <http://ochealthinfo.com/phs/about/dcepi/hiv> **OR**
- 2) Put the completed paper survey in the box marked "Client Needs Surveys" in the location you received the survey. **OR**
- 3) Put the completed paper survey in a mailbox. You do not need to put a stamp on the envelope.

Thank you again for your assistance. With your help, we hope that we can better plan for the needs of our community. Please contact Mindy He at (714) 834-8063 if you have any questions.

Sincerely,

Rutherford Cravens
Chair-Orange County HIV Planning Council

Tamarra Jones, DrPH
HIV Planning and Coordination

2013 Client Needs Survey

Orange County HIV Planning Council

For each of the services (a-x) listed below, please answer questions 1 and 2. Please answer question 3, if applicable.

1.
Did you **NEED** any of the services listed below in the past 12 months (even if you did not get it)?

2.
Did you **RECEIVE** any of the services listed below in the past 12 months? (If NO, answer #3)

3.
If you answered "NO" to question 2, please check the reason(s) you did not get the service on pages 1 and 2.

SERVICES	1.		2.		3.												
	YES	NO	YES	NO	Didn't qualify (please describe using question 27)	Didn't know about service	Didn't know where to go	There was a waiting list	Didn't have transportation	Needed child care	Immigration status	Language difficulty	In jail or prison	No stable address	The process was too complicated	Unknown/confused	Other (please describe using question 27)
a. Medical Care - Doctor visits, tests & procedures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
b. Education and Support with Medications - Education about & assistance with taking meds, side effects, & interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
c. Emergency Financial Assistance For Medications - Financial help to get medications & for insurance payments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
d. Medical Case Management - Help accessing and/or maintaining medical care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
e. Non-Medical Case Management - Help with general referrals to services, applying for benefits, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
f. Dental Care (Basic) - Cleaning, exams, fillings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
g. Dental Care (Advanced) - Crowns, dentures, bridges	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
h. Mental Health Services (Individual) - One-on-one counseling by a counselor/therapist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
i. Mental Health Services (Group) - Group counseling or support groups	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
j. Mental Health Services (Psychiatric) - Evaluations & medications by Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													
k. Drug and Alcohol Residential Treatment - Treatment in residential facility for substance abuse issues	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>													

This survey is ANONYMOUS. Please do not write your name on this survey.

Please complete and return by April 30, 2013. Thank you for your help!

Please return to: Orange County Health Care Agency, P.O. Box 6099, Santa Ana CA, 92706

Questions? Need Help? Call (714) 834-8063

4. On pages 1 and 2 (services a-x), please circle the five (5) services that are most important to you.

5. What are the biggest problems you have had in getting services you need?

a) _____

b) _____

6. Where have you received services in the last 12 months? (Check all that apply.)

17th Street Care Clinic (County of Orange HIV Clinic)

17th Street Dental Clinic

AIDS Services Foundation Orange County (ASF)

APAIT Health Center (APAIT)

Delhi Center

Gerry House or Start House

Laguna Beach Community Clinic

Public Law Center

REACH

Shanti Orange County

The Center Orange County

Ruben Begino, DDS (Bristol Family Dental)

Carlos Garcia, DDS

Aida Shahangian, DDS

Other: _____

7. Where have you received HIV-related medical services in the last 12 months? (Check all that apply.)

Emergency Room

Urgent Care

Kaiser Permanente

Jail/Prison

Laguna Beach Community Clinic

17th Street Care Clinic (County of Orange HIV Clinic)

UCI Medical Center

Private Doctor (Name): _____

Other: _____

8. Since you were diagnosed, have you ever gone more than 12 months without seeing a doctor? Yes No

9. Do you have a regular doctor (either a primary care physician or HIV specialist)? Yes No

10. In the past 12 months, about how many times have you seen your regular doctor (either a primary care physician or HIV specialist)?

None Less than 4 4 to 8 More than 8

11. In the past 12 months, have you gone to an emergency room for an HIV-related issue? Yes No

11a. If so, how many times were you admitted? _____

12. What types of transportation do you usually take to get to services? (Check all that apply.)

My car Bus Ride from friend/relative

Provider Van None Other _____

13. Do you have a copy of the Client Handbook that describes HIV/AIDS services available in Orange County?

Yes No If No, please call (714) 834-8711 for a copy

Please help us better understand your needs by telling us a few things about yourself. Information you provide will not be used to discriminate or prevent you from receiving needed services.

14. What city do you live in? _____

15. If you were born outside of the U.S., how long have you lived in the U.S.? _____

16. What is your race/ethnicity?

- African-American or Black American Indian/Alaskan Native
 Anglo/White Asian or Pacific Islander
 Hispanic/Latino(a) Other _____

17. What language are you most comfortable speaking?

- English Vietnamese Spanish Other _____

18. What is your age? _____

19. What is your gender?

- Male Transgender Male to Female
 Female Transgender Female to Male

20. What is your sexual orientation?

- Heterosexual/Straight Gay Bisexual
 Decline to state Other _____

21. In the last 12 months, how often have you used street drugs or drugs that weren't prescribed to you?

- Daily A few (1-3) times a week
 A few (1-3) times a month Not at all
 Other _____

22. In the past 12 months, check if you have been in any of the following situations (check all that apply):

- Homeless (no regular housing)
 In temporary/transitional housing in a motel or program
 Jail Not applicable Other _____

23. Are you disabled and unable to work full time because of health problems?

- Yes No

21a. If you are disabled, is it due to HIV/AIDS?

- Yes No Not applicable

24. What is your monthly income?

- Less than \$908 \$909 - \$1,361 \$1,362 - \$1,815
 \$1,816 - \$2,269 \$2,270 - \$2,723 More than \$2,723

22a. INCLUDING YOURSELF, how many people are supported by this income? _____

25. In what year were you first diagnosed with HIV? _____

23a. Do you have an AIDS diagnosis?

- Yes No I don't know

23b. If yes, what year were you diagnosed with AIDS?

26. In the past three months, which of these have you used to pay for your HIV related medical bills and/or HIV related medications? (Please check all that apply.)

- ADAP (AIDS Drug Assistance Program)
 CalOptima (Medi-Cal/Medicaid)
 Community Clinic (Laguna Beach or others)
 Medicare
 Medi/Medi (Medi-Cal and Medicare)
 MSI (Medical Services Initiative)/LIHP
 17th St. Care Clinic (County of Orange HIV Clinic)
 Private Insurance (paid by self or employer)
 VA (Veterans Administration)
 Myself (out of pocket)
 I don't know Other: _____

