

Consumer Survey

We are conducting a survey on the needs of people who are receiving medical care for HIV. This will take only a few minutes to complete. Your participation is voluntary, your responses will be kept confidential, and you can decline to answer any of the questions. **Have you answered this survey before? If YES, please do not complete another survey form.**

1. **Gender** Male Female Other
2. **Sexual Identification** Heterosexual Men who has sex with men
 Woman who has sex with women Bisexual Transsexual Transgendered
3. Are you **Hispanic or Latino?** Yes No
4. **Race** American Indian/Alaska Native Asian White
 Black or African American Native Hawaiian/Other Pacific Islander
5. **Current Age:** Under 13 Age 13 – 24 Age 25 - 44 Age 45 and older
6. In what **county do you reside?**
 Essex Union Morris Warren Sussex Other _____
7. What is your **ZIP Code** where you currently live? (Enter) _____
8. **When were you diagnosed with HIV/AIDS?**
 Within the past year 2 to 4 years ago 5 to 10 years ago 11 to 15 years ago
 15+ years ago
9. Do you currently receive **Medical Care for your HIV?** Yes No
- 9a. **If no, why not?** I do not feel sick I cannot afford the cost
 No rush. HIV can be cured with a pill. I do not trust the system
 Other (list) _____

**IF YOU DO NOT RECEIVE MEDICAL CARE FOR YOUR HIV/AIDS, YOU ARE FINISHED.
THANK YOU!**

IF YOU RECEIVE MEDICAL CARE, PLEASE CONTINUE.

10. **How long after your HIV/AIDS diagnosis did you wait to seek medical care?**
 I did not wait; I immediately began seeing the doctor Less than 6 months
 6 months to one year 1 year to 3 years 3 to 5 years
 6 to 8 years More than 8 years
11. **What type of medical insurance do you have?**
 Medicaid Medicare Private Charity Care None

PLEASE CONTINUE ON OTHER SIDE



12. **Other Services Needed.** In addition to medical care, what other health services do you **NEED**? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Substance abuse treatment - methadone |
| <input type="checkbox"/> Substance abuse treatment - detox | <input type="checkbox"/> Medical nutritional therapy |
| <input type="checkbox"/> Substance abuse treatment – hospital | <input type="checkbox"/> Medical case management |
| <input type="checkbox"/> Substance abuse treatment – residential | <input type="checkbox"/> Treatment adherence |
| <input type="checkbox"/> Substance abuse treatment – outpatient | <input type="checkbox"/> Oral health (dental) care |

13. **Other Services Used.** In addition to medical care, what other health services do you **CURRENTLY USE OR HAVE USED**? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Substance abuse treatment - methadone |
| <input type="checkbox"/> Substance abuse treatment - detox | <input type="checkbox"/> Medical nutritional therapy |
| <input type="checkbox"/> Substance abuse treatment – hospital | <input type="checkbox"/> Medical case management |
| <input type="checkbox"/> Substance abuse treatment – residential | <input type="checkbox"/> Treatment adherence |
| <input type="checkbox"/> Substance abuse treatment – outpatient | <input type="checkbox"/> Oral health (dental) care |

14. **Services Needed but Not Used.** In addition to medical care, what other health services do you **NEED OR KNOW ABOUT BUT DO NOT USE**? (Check all that apply.)

- | | |
|--|--|
| <input type="checkbox"/> Mental health services | <input type="checkbox"/> Substance abuse treatment - methadone |
| <input type="checkbox"/> Substance abuse treatment - detox | <input type="checkbox"/> Medical nutritional therapy |
| <input type="checkbox"/> Substance abuse treatment – hospital | <input type="checkbox"/> Medical case management |
| <input type="checkbox"/> Substance abuse treatment – residential | <input type="checkbox"/> Treatment adherence |
| <input type="checkbox"/> Substance abuse treatment – outpatient | <input type="checkbox"/> Oral health (dental) care |

15. **Reasons.** Please give reasons for why you have not used these services.

- | | |
|---|---|
| <input type="checkbox"/> No transportation | <input type="checkbox"/> No child care |
| <input type="checkbox"/> Services not available in my area | <input type="checkbox"/> I cannot afford the cost |
| <input type="checkbox"/> I do not need services that badly | <input type="checkbox"/> Received bad service |
| <input type="checkbox"/> Not culturally appropriate | |
| <input type="checkbox"/> Language barriers? If yes what Language? _____ | |
| <input type="checkbox"/> Other (list) _____ | |

16. **Housing.** Do you need assistance with **Housing**? Yes No
Please describe. _____

17. **Do you need any other services?** Yes No
Please describe. _____

18. **Do you have any other comments that you would like to make?**

Thank you for participating! Your responses will help the Newark EMA HIV Health Services Planning Council make recommendations about the needs of individuals with HIV in the counties of Essex, Morris, Sussex, Union and Warren. If you would like to see the results of this survey, they will be available by contacting the Newark EMA HIV Health Services Planning Council at (973) 485-5220 after July 31, 2008.