

**FY20 NEEDS AND RESOURCES ASSESSMENT**

Community Service Provider Survey

Thank you for taking time to complete this survey. Your input greatly assists us in getting a better picture of the programs and services provided in our community. All information requested will remain confidential.

**Agency Name**:

**Position:**

**Address:**

**Phone Number:**

**Email:**

1. **Please provide the type of organization: (Check all that apply.)**

\_\_\_\_For Profit \_\_\_\_Non for Profit \_\_\_\_State Agency

\_\_\_\_Local Government (Municipal) \_\_\_\_County Government \_\_\_\_Community Based

\_\_\_\_Faith-Based \_\_\_\_Civic

\_\_\_\_Other (please specify):

1. **How long has your program been in operation?** Number of Years \_\_\_\_\_\_\_\_\_\_\_\_

**How long has your program been at its current location?** Number of Years \_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Please check the services that your organization provides for children and youth:**

\_\_\_\_Child care \_\_\_\_Afterschool care \_\_\_\_Tutoring

\_\_\_\_Recreation \_\_\_\_Counseling services \_\_\_\_Mental health services

\_\_\_\_Literacy programs (please specify ages):

\_\_\_\_Summer programs (please specify ages):

\_\_\_\_Other (please specify):

1. **Please check the services that your organization provides for adults:**

\_\_\_\_GED/diploma \_\_\_\_Workforce development/job training

\_\_\_\_Mental health services \_\_\_\_Substance abuse services

\_\_\_\_Family services \_\_\_\_Social services \_\_\_\_Housing services

\_\_\_\_Other (please specify):

1. **Do you provide services to children that are Medicaid eligible exclusively?** \_\_\_\_Yes \_\_\_\_No

 If no, where do you refer them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **How many, if any, of the infants and toddlers in your care receive services for special needs?**

|  |  |
| --- | --- |
| Total Number of Children | Ages of Children |
|  |  |
|  |  |

**FIRST STEPS AND COLLABORATION**

1. **Had your agency/organization heard of First Steps before now?** \_\_\_\_\_Yes \_\_\_\_\_\_No
2. **Does your agency currently participate as a partner with First Steps?** \_\_\_\_\_Yes \_\_\_\_\_\_No

**If yes, how do you participate? (Check all that apply.)**

\_\_\_\_My agency/organization provides direct services to children participating in a First Steps funded program(s)

\_\_\_\_My agency/organization provides indirect services to children participating in a First Steps funded program(s)

\_\_\_\_My agency/organization designates a person to attend First Steps meetings on a regular basis.

\_\_\_\_My agency/organization receives supplies and materials from First Steps.

\_\_\_\_My agency/organization access resources and materials through a First Steps-funded resource.

\_\_\_\_My agency/organization makes referrals to other First Steps-funded program(s).

\_\_\_\_Other (Please specify):

1. **What are the barriers that prevent your agency/organization from participating in First Steps Initiatives? (Check all that apply.)**

\_\_\_Time commitment \_\_\_Time of board meetings

\_\_\_Day of board meetings \_\_\_Location of board meetings

\_\_\_Don‘t know enough about First Steps

Other (Please Specify):

1. **Based on your involvement as a Community Service Provider, are the healthcare needs of children being met in your county?**
2. **What is the greatest obstacle to children receiving adequate healthcare (Please select only one choice)?**

\_\_\_Lack of transportation \_\_\_Lack of health benefits \_\_\_Lack of information and knowledge

\_\_\_The cost of healthcare \_\_\_Other (please specify):

1. **As a Community Service Provider, what is the greatest health need in your community?**

**(Please select all needs that apply)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Need Category** | **Young Children****(0-5)** | **Children****(6-17)** | **Adults****(18-54)** | **Seniors****(55+)** |
| Lack of Pediatric Doctors |  |  |  |  |
| Lack of Dental Services |  |  |  |  |
| Lack of OB/GYN Doctors |  |  |  |  |
| Lack of Specialist Doctors |  |  |  |  |
| Lack of Occupational/Speech Therapists |  |  |  |  |
| Lack of Speech Therapists |  |  |  |  |
| Lack of Affordable Health Services |  |  |  |  |
| Lack of Affordable Health Insurance |  |  |  |  |
| Lack of Physical Therapists |  |  |  |  |
| Lack of Comprehensive Health Services |  |  |  |  |
| Other (Please Specify): |  |  |  |  |

1. **Is there anything else you like to tell us regarding other services needed or the state of children 0-5 in your county?**

THANK YOU FOR YOUR TIME & INPUT!