



Every three years Bishop Indian Head Start will conduct a community needs assessment to collect data about community strengths, needs, and resources. Bishop Indian Head Start will use this data to make decisions about long and short term goals, selection criteria, the type of services provided for children and families and to determine collaboration possibilities with other agencies. The purpose of this survey is to assess our current service outcomes, target service areas of improvement and if determined enhance our current Head Start services. Data will be updated each year as needed. Your feedback is very important and will be kept confidential. Thank you for taking the time to answer these questions.

Tell Us about Yourself		
1. What category best describes you?		
<input type="checkbox"/> Parent working out of home	<input type="checkbox"/> Parent in school (college/Vocational)	
<input type="checkbox"/> Parent working in the home	<input type="checkbox"/> Parent not working	
<input type="checkbox"/> Grandparent/Guardian	<input type="checkbox"/> Foster Parent	
<input type="checkbox"/> Teen Parent	<input type="checkbox"/> Other _____	
2. Your gender:		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	
3. 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"/> 52-58	<input type="checkbox"/> Over 60
4. Your ethnicity/race:		
<input type="checkbox"/> Native American/Alaskan	<input type="checkbox"/> African American	<input type="checkbox"/> Caucasian
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Asian/Pacific	<input type="checkbox"/> Other _____
5. What is the primary language spoken in your home:		
<input type="checkbox"/> English	<input type="checkbox"/> Tribal	<input type="checkbox"/> Spanish
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you or your spouse a Head Start graduate?		
<input type="checkbox"/> Yourself	<input type="checkbox"/> Spouse	<input type="checkbox"/> Other children in family
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No

Tell Us about Your Family		
7. What is your marital status?		
<input type="checkbox"/> Single	<input type="checkbox"/> Separated	
<input type="checkbox"/> Married	<input type="checkbox"/> Living with my partner	
<input type="checkbox"/> Divorced	<input type="checkbox"/> Widowed	
8. Which of the following best describes your family? (Check only one)		
<input type="checkbox"/> Two Parent Family	<input type="checkbox"/> Female Head of Household, no husband	
<input type="checkbox"/> Male Head of Household, no wife	<input type="checkbox"/> Other	
9. How many adults, including yourself, live in your household?		

10. How many children live with you? (under 18 years old)		

11. How many children live with you? (under 5 years old)		
Ages:		
Between 0-1 years _____ 2 years _____ 3years _____ Between 4-5Years _____		
Tell Us about Your Family's Home		
12. About your home, does your family:		
<input type="checkbox"/> Rent	<input type="checkbox"/> Live with other people	<input type="checkbox"/> Own
<input type="checkbox"/> Other	<input type="checkbox"/>	<input type="checkbox"/>

13. About your living situation, does your family live:		
<input type="checkbox"/> Alone as a family	<input type="checkbox"/> With relatives	<input type="checkbox"/> With friends
<input type="checkbox"/> In a shelter	<input type="checkbox"/> Homeless	<input type="checkbox"/> Other

Tell Us about Your Family's Health Care

14. What type of health insurance do you have?		
<input type="checkbox"/> None	<input type="checkbox"/> Provided through work	
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Other:	
15. Are your children covered with the same insurance, another type of insurance, or not covered at all?		
<input type="checkbox"/> Same insurance	<input type="checkbox"/> Different insurance	<input type="checkbox"/> Not insured
16. Where do you usually take your child to get medical care? (Check all that apply)		
<input type="checkbox"/> Family doctor	<input type="checkbox"/> Community Health Clinic	<input type="checkbox"/> Emergency room
<input type="checkbox"/> Family dentist	<input type="checkbox"/> Indian Health Service	<input type="checkbox"/> Other_____
17. In your opinion, what should be done to make quality health care more available to families in your community? (Check all that apply)		
<input type="checkbox"/> Decrease cost	<input type="checkbox"/> Provide transportation	
<input type="checkbox"/> Increase the number of health centers	<input type="checkbox"/> Provide more information about available health care	

Tell Us about Your Transportation

18. How does your child get to School?		
<input type="checkbox"/> Car	<input type="checkbox"/> Head Start transportation	<input type="checkbox"/> Taxi
<input type="checkbox"/> Carpool	<input type="checkbox"/> City School bus	<input type="checkbox"/> Walk
19. Do you have a reliable car?		
<input type="checkbox"/> No	<input type="checkbox"/> Yes, car is reliable	

Tell Us about Your Employment

20. Are you currently? (Mark one each for you and your spouse)		
Yourself		Spouse or Partner
<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"/>

Tell Us about Your Child Care Needs

21. Do you need child care for your children on a regular basis?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	
22. What type(s) of child care are you currently using?		
<input type="checkbox"/> Older siblings	<input type="checkbox"/> Relatives	<input type="checkbox"/> Babysitter in the home
<input type="checkbox"/> Licensed Family Child Care	<input type="checkbox"/> Licensed Child Care Center	<input type="checkbox"/> Head Start
23. What was the main factor that influenced your decision about the child care arrangement you currently have?		
<input type="checkbox"/> Cost was affordable	<input type="checkbox"/> Location near home or work	<input type="checkbox"/> My child would be safe
<input type="checkbox"/> Program has accreditation	<input type="checkbox"/> Referral from family or friend	<input type="checkbox"/>
24. What types of child care have you needed in the last 12 months?		
<input type="checkbox"/> Full-day care	<input type="checkbox"/> Half-day care	<input type="checkbox"/> Before/after school care
<input type="checkbox"/> Night or weekend care	<input type="checkbox"/> None	<input type="checkbox"/>
25. Please check the periods that you most need child care during the week?		
<input type="checkbox"/> Mornings only	<input type="checkbox"/> Evenings only	<input type="checkbox"/> Weekends
<input type="checkbox"/> Afternoons only	<input type="checkbox"/> Highly varying hours and days	<input type="checkbox"/>

26. How difficult is it for you to arrange back-up child care when your regular childcare arrangement doesn't work?

<input type="checkbox"/> Very difficult	<input type="checkbox"/> Some what difficult	<input type="checkbox"/> Not at all difficult
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27. How difficult is it for you to find child care for your children in the summer months when Head Start is not in session?

<input type="checkbox"/> Very difficult	<input type="checkbox"/> Some what difficult	<input type="checkbox"/> Not at all difficult
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Tell Us about Your Income

28. 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"/> Over \$60,000	<input type="checkbox"/>

29. Do you get any type of Public Assistance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No
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30. If so, what kind of Public Assistance do you get?

<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF	<input type="checkbox"/> Social Security
<input type="checkbox"/> Food Stamps	<input type="checkbox"/> Tribal benefits	<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 Education

31. Indicate the highest level of education completed by: (Mark one for you and your spouse/partner)

Yourself		Spouse (Partner)	
<input type="checkbox"/>	Some to no high school education	<input type="checkbox"/>	
<input type="checkbox"/>	High School graduate/GED	<input type="checkbox"/>	
<input type="checkbox"/>	Vocational School	<input type="checkbox"/>	
<input type="checkbox"/>	Some College	<input type="checkbox"/>	
<input type="checkbox"/>	AA degree (2 year degree)	<input type="checkbox"/>	
<input type="checkbox"/>	Bachelor's degree	<input type="checkbox"/>	
<input type="checkbox"/>	Some graduate school	<input type="checkbox"/>	
<input type="checkbox"/>	Master's Degree	<input type="checkbox"/>	

32. Are you or your spouse/partner currently in school? (Mark one for you and your spouse/partner)

Yourself		Spouse	
<input type="checkbox"/>	No	<input type="checkbox"/>	
<input type="checkbox"/>	Yes, full-time	<input type="checkbox"/>	
<input type="checkbox"/>	Yes, part-time	<input type="checkbox"/>	

Tell Us about Your Community

33. What do you consider to be barriers that prevent families from getting needed services? (Check only those that apply to you and your family)

<input type="checkbox"/> Not aware of existing services	<input type="checkbox"/> Services are too far away 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"/> Agencies fees are too high	<input type="checkbox"/> Rules and eligibility exclude people
<input type="checkbox"/> Agencies staff are rude	<input type="checkbox"/> Concerns about confidentiality
<input type="checkbox"/> Uncomfortable with "outsiders"	<input type="checkbox"/> None

34. 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	<input type="checkbox"/> Budgeting income	<input type="checkbox"/> Housing improvements
<input type="checkbox"/> Resources in the Community	<input type="checkbox"/> Emergency Rent, utility	<input type="checkbox"/> Transportation



35. 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

Tell Us How We Are Doing?

36. How did you hear about Head Start?	
<input type="checkbox"/> Friends/Relatives	<input type="checkbox"/> Doctor's Office
<input type="checkbox"/> Dental Office	<input type="checkbox"/> Head Start Staff
<input type="checkbox"/> Head Start flyer or brochure	<input type="checkbox"/> Elementary School
<input type="checkbox"/> Head Start Round-Up	<input type="checkbox"/> Other

37. Have you volunteered in the Head Start Program?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

38. If you have volunteered please check all of the ways you have volunteered?	
<input type="checkbox"/> Helping in the classroom	<input type="checkbox"/> Helping with fieldtrips
<input type="checkbox"/> Helping on the bus	<input type="checkbox"/> Servicing on Center Parent Committee
<input type="checkbox"/> Servicing on Policy Council	<input type="checkbox"/> Servicing on Health/Nutrition Committee
<input type="checkbox"/> Servicing on Education Committee	<input type="checkbox"/> Translating, verbal or written
<input type="checkbox"/> Special Projects	<input type="checkbox"/> Special Events

39. To help us plan for the future would you please tell us what program would best fit your needs?	
<input type="checkbox"/> Home based program with 1 home visit a week	
<input type="checkbox"/> Full day-full year program; five days a week; year round (8:00 am-5:00pm)	
<input type="checkbox"/> Full day program; five days per week; 10 months a year (8:00 am-2:30pm)	
<input type="checkbox"/> Early Head Start (Infants and Toddlers)	

40. What hours of operation would be the most beneficial for you and your family?			
<input type="checkbox"/> 7:30am to 5:30pm	<input type="checkbox"/> 8am to 5pm	<input type="checkbox"/> 8am to 2:30pm	<input type="checkbox"/> 7:30am to 2:30pm

41. If your child went to BIHS, please rate your experience:				
Please Check One:	Very Good	Good	Needs Improvement	Unacceptable
How understandable was the orientation you received to participate in the Head Start Program?				
How understandable were the application forms?				
How well do you think the staff answered your questions?				
Did Head Start assist in your child's education?				
How well do you think staff respected your opinions, ideas, and concerns?				
What was the condition of the Head Start facility, including classroom?				
What was the condition of the Head Start playground?				
How would you rate the individualized attention your family received from Head Start?				
Overall, how would you rate your child's experience in the classroom?				
Overall, how would you rate your experience in the Head Start program?				

42. What areas of the Head Start program do you feel could use improvements?	
<input type="checkbox"/> Education/Literacy	<input type="checkbox"/> Nutrition & Meal Service
<input type="checkbox"/> Health Assessment/Follow-up	<input type="checkbox"/> Disabilities Assessment/Follow-up
<input type="checkbox"/> Family/Community Partnerships	<input type="checkbox"/> Classroom Environment
<input type="checkbox"/> Curriculum	<input type="checkbox"/> Playground
<input type="checkbox"/> Transportation	<input type="checkbox"/> Culture
<input type="checkbox"/> Mental Health	<input type="checkbox"/>

43. Please list suggested improvements for the program.

Tell Us about Your Training Interest?

44. Please specify your interest 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"/> CPR & First Aid	<input type="checkbox"/> Stress Management
<input type="checkbox"/> Food Preparation	<input type="checkbox"/> Health, Wellness & Hygiene
<input type="checkbox"/> Time Management	<input type="checkbox"/> Fire Prevention Training
<input type="checkbox"/> Child Car Seat Safety	<input type="checkbox"/> Child Development
<input type="checkbox"/> Program Governance	

45. Please tell us what Community Services on or off the Reservation you have used?

<input type="checkbox"/> Hüübü program:
<input type="checkbox"/> Bishop Indian Head Start:
<input type="checkbox"/> Education Center:
<input type="checkbox"/> Youth Activities:
<input type="checkbox"/> College and Career Counseling:
<input type="checkbox"/> Student Services:
<input type="checkbox"/> Elders Program:
<input type="checkbox"/> Environmental Programs:
<input type="checkbox"/> Tribal Police:
<input type="checkbox"/> ROSS Services:
<input type="checkbox"/> Community Project Activities:
<input type="checkbox"/> Social Services:
<input type="checkbox"/> ICWA:
<input type="checkbox"/> Women’s Legal Advocacy Program:
<input type="checkbox"/> Tribal Court:
<input type="checkbox"/> Public Works:
<input type="checkbox"/> TERO:
<input type="checkbox"/> Owens Valley Career Development Center:
<input type="checkbox"/> Day Care:
<input type="checkbox"/> Tuniwa Nobi Family Literacy:
<input type="checkbox"/> Tribal TANF
<input type="checkbox"/> Nüümü Yadoha (Language Program)
<input type="checkbox"/> Cerro Coso:
<input type="checkbox"/> Other

Comments/Suggestions:

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Thank you for your participation in the BIHS Community Needs Planning!