



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 or in (college/vocational) | <input type="checkbox"/> Parent not working or in (college/Vocational) | | |
| <input type="checkbox"/> Guardian working or in (college/vocational) | <input type="checkbox"/> Guardian not working or in (college/Vocational) | | |
| <input type="checkbox"/> Grandparent working or in (college/vocational) | <input type="checkbox"/> Grandparent not working or in (college/Vocational) | | |
| <input type="checkbox"/> Teen Parent working or in (college/vocational) | <input type="checkbox"/> Teen Parent not working or in (college/Vocational) | | |
| <input type="checkbox"/> Foster Parent or in (college/vocational) | <input type="checkbox"/> Foster Parent not or in (college/Vocational) | | |
| <input type="checkbox"/> None of the above. Please describe: _____ | | | |
| 2. Your gender | | | |
| <input type="checkbox"/> Male | | <input type="checkbox"/> Female | |
| 3. Your age | | | |
| <input type="checkbox"/> 17 and under | <input type="checkbox"/> 18-25 | <input type="checkbox"/> 26-35 | |
| <input type="checkbox"/> 36-45 | <input type="checkbox"/> 46-55 | <input type="checkbox"/> 56 and Over | |
| 4. Your ethnicity/race (check all that apply) | | | |
| <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? (check all that apply) | | | |
| <input type="checkbox"/> Paiute | <input type="checkbox"/> English | <input type="checkbox"/> Spanish | |
| <input type="checkbox"/> Other | <input type="checkbox"/> Other | <input type="checkbox"/> Other | |
| 6. Is anyone in your household a Head Start graduate? (check all that apply) | | | |
| <input type="checkbox"/> Yourself | <input type="checkbox"/> Spouse | <input type="checkbox"/> Other children in family | <input type="checkbox"/> None |

| 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"/> Two or more Family Household | | |
| 9. How many adults, including yourself, live in your household? _____ | | | |
| 10. How many children live in your household? (under 18 years old) _____ | | | |
| 11. How many children live in your household? (under 5 years old) | | | |
| Ages: | | | |
| Between 0-1 years # _____ | 2 years # _____ | 3 years # _____ | Between 4-5 years # _____ |
| Tell Us about Your Family's Home | | | |
| 12. About your home, does your family live in a: | | | |
| <input type="checkbox"/> House, you own | <input type="checkbox"/> Mobile, you own | <input type="checkbox"/> Apartment (rent) | |
| <input type="checkbox"/> House, you rent | <input type="checkbox"/> Mobile, you rent | <input type="checkbox"/> Rent a room from other family | |



| 13. About your living situation, does your family live:1 | | |
|---|--|--|
| <input type="checkbox"/> Alone as a family | <input type="checkbox"/> With another family or person because of loss of housing or as a result of economic hardship (sometimes referred as “doubled-up”) | |
| <input type="checkbox"/> In a shelter | <input type="checkbox"/> In a hotel/motel | <input type="checkbox"/> In a car, park, or campsite |

Tell Us about Your Family’s Health and Dental Care

| 14. Does your family have access to affordable Health Care Services? | | |
|--|---|---|
| <input type="checkbox"/> Yes Type of insurance: | <input type="checkbox"/> No, why not? | |
| 15. Does your family have access to affordable Dental Health Care Services? | | |
| <input type="checkbox"/> Yes, Type of insurance: | <input type="checkbox"/> No, why not? | |
| 16. Does your family have access to affordable Mental Health Care Services? | | |
| <input type="checkbox"/> Yes, Type of insurance: | <input type="checkbox"/> No, why not? | |
| 17. 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 _____ |
| 18. 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 | |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Other _____ | |

Tell Us about Your Transportation

| 19. How does your family get your child(ren)to School or childcare? | | |
|--|--|---|
| <input type="checkbox"/> Car | <input type="checkbox"/> Head Start transportation | <input type="checkbox"/> Bike |
| <input type="checkbox"/> Ride with a friend | <input type="checkbox"/> Public transportation | <input type="checkbox"/> Walk, How many miles _____ |
| 20. Do you have a reliable car? | | |
| <input type="checkbox"/> No | <input type="checkbox"/> Yes, car is reliable | |
| 21. Would you like to see improvement to any of the following on the reservation? | | |
| <input type="checkbox"/> Sidewalks around Educational Services | <input type="checkbox"/> Bike and Walking Paths to Schools | |

Tell Us about Your Employment

| 22. Are you currently? (Mark one each for you and your spouse/partner) | | | |
|---|---------------------|--------------------------|--|
| 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

| 23. Do you need childcare for your children on a regular basis? | | |
|--|---|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | |
| 24. What type(s) of childcare are you currently using? (Check all that apply) | | |
| <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/Early Head Start |
| 25. What was the main factor that influenced your decision about the childcare arrangement you currently have? (Check all that apply) | | |
| <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"/> Other _____ |



| | | |
|--|--|---|
| 26. What types of childcare have you needed in the last 12 months? (Check all that apply) | | |
| <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"/> Other |
| 25. Please check the periods that you most need childcare during the week? (Check all that apply) | | |
| <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"/> Other |
| 26. How difficult is it for you to arrange back-up childcare when your regular childcare arrangement doesn't work? | | |
| <input type="checkbox"/> Very difficult | <input type="checkbox"/> Somewhat difficult | <input type="checkbox"/> Not at all difficult |
| 27. How difficult is it for you to find childcare for your children in the summer months when Head Start is not in session? | | |
| <input type="checkbox"/> Very difficult | <input type="checkbox"/> Somewhat difficult | <input type="checkbox"/> Not at all difficult |

Tell Us about Your Income

| | | | |
|--|--|---|--|
| 28. What is your Source of Household Income? (Check all that apply) | | | |
| <input type="checkbox"/> Full-time Employment | <input type="checkbox"/> Self-Employed | <input type="checkbox"/> TANF/Cal Works | <input type="checkbox"/> Retirement |
| <input type="checkbox"/> Part-time Employment | <input type="checkbox"/> Seasonal Worker | <input type="checkbox"/> SSI | <input type="checkbox"/> Tribal Distribution/Per Cap |
| <input type="checkbox"/> No income, Other Family or other people provide food and shelter for my family. | | | |
| 29. To the best of your knowledge is your combined family income? (See FPG Chart below) | | | |
| <input type="checkbox"/> Below Federal Poverty Guidelines | <input type="checkbox"/> At Federal Poverty Guidelines | <input type="checkbox"/> Above Federal Poverty Guidelines | |

2020 POVERTY GUIDELINES FOR THE 48 CONTIGUOUS STATES AND THE DISTRICT OF COLUMBIA

| PERSONS IN FAMILY/HOUSEHOLD | POVERTY GUIDELINE |
|--|--------------------------|
| For families/households with more than 8 persons, add \$4,180 for each additional person. | |
| 1 | \$12,760 |
| 2 | \$17,240 |
| 3 | \$21,720 |
| 4 | \$26,200 |
| 5 | \$30,680 |
| 6 | \$35,160 |
| 7 | \$39,640 |
| 8 | \$44,120 |

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"/> | Trade/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"/> |
| <input type="checkbox"/> | Doctorate Degree | <input type="checkbox"/> |

| 32. Are you or your spouse/partner currently in school? (Mark one for you and your spouse/partner) | | | |
|---|----------------|--------------------------|--|
| Yourself | | Spouse/Partner | |
| <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 are not open at convenient time |
| <input type="checkbox"/> Childcare 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 (Check only those that apply to you and your family)

| | | |
|---|--|--|
| <input type="checkbox"/> Education/Job Training | <input type="checkbox"/> Employment Services | <input type="checkbox"/> Vehicle repairs |
| <input type="checkbox"/> Health Services | <input type="checkbox"/> Budgeting income | <input type="checkbox"/> Housing improvements |
| <input type="checkbox"/> Dental Services | <input type="checkbox"/> Emergency Rent | <input type="checkbox"/> Domestic Violence Prevention |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> Transportation | <input type="checkbox"/> Child Abuse Prevention |
| <input type="checkbox"/> Nutrition Services | <input type="checkbox"/> Parenting Workshops | <input type="checkbox"/> Water/Sewer hook ups |
| <input type="checkbox"/> Food | <input type="checkbox"/> Heating Home | <input type="checkbox"/> Electricity / Propane |
| <input type="checkbox"/> Clothing | <input type="checkbox"/> Cooling Home | <input type="checkbox"/> Finding Community Resources to assist you in meeting your family needs. |

Tell Us How We Are Doing?

35. How did you hear about Head Start?

| | |
|---|---|
| <input type="checkbox"/> Friends/Relatives | <input type="checkbox"/> Mental Health Office |
| <input type="checkbox"/> Dental or Doctor Office | <input type="checkbox"/> Head Start Staff |
| <input type="checkbox"/> Head Start flyer or brochure | <input type="checkbox"/> Early Head Start Staff |
| <input type="checkbox"/> Bishop Tribal Radio | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Elementary School | <input type="checkbox"/> Other: _____ |

36. If you have volunteered at Head Start, 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 |

37. Would you please tell us what program would best fit your needs?

| |
|--|
| <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) |

38. If your child went to BIHS, please rate your experience:

| Please Check One: | Very Good | Good | Needs Improvement | Unacceptable |
|---|------------------|-------------|--------------------------|---------------------|
| 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? | | | | |
| What was the condition of the Head Start playground? | | | | |

| Please Check One: | Very Good | Good | Needs Improvement | Unacceptable |
|---|-----------|------|-------------------|--------------|
| How would you rate the individualized attention your family received from Head Start? | | | | |
| Overall, how would you rate your experience in the Head Start program? | | | | |

39. Please describe suggested improvements for the Head Start program.

Tell Us about Your Training Interest?

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

| | |
|---|---|
| <input type="checkbox"/> Child Abuse & Neglect | <input type="checkbox"/> Family Fitness |
| <input type="checkbox"/> Child Growth & Development | <input type="checkbox"/> Gardening |
| <input type="checkbox"/> Parenting Skills | <input type="checkbox"/> Volunteering in the Community |
| <input type="checkbox"/> Continuing Education Training | <input type="checkbox"/> Technical or Vocational Training |
| <input type="checkbox"/> Dental Care | <input type="checkbox"/> Self-Esteem |
| <input type="checkbox"/> Domestic Violence | <input type="checkbox"/> Substance Abuse |
| <input type="checkbox"/> Employment Training | <input type="checkbox"/> Domestic Violence |
| <input type="checkbox"/> CPR & First Aid/AED /NARCAN | <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"/> Computer Training |
| <input type="checkbox"/> Program Governance | <input type="checkbox"/> Money Management |
| <input type="checkbox"/> Challenging Behavior | <input type="checkbox"/> Elder Care |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Other |
| <input type="checkbox"/> Navigating through Community Resources | <input type="checkbox"/> Other |

41. Please tell us what Community Services on or off the Reservation you have used and your experience with those services?

| |
|---|
| <input type="checkbox"/> OVCD Early Head Start: |
| <input type="checkbox"/> Bishop Indian Head Start: |
| <input type="checkbox"/> Bishop Tribal Education Center: |
| <input type="checkbox"/> Bishop Tribal Youth Activities: |
| <input type="checkbox"/> OVCD College and Career Counseling: |
| <input type="checkbox"/> OVCD Student Services: |
| <input type="checkbox"/> Bishop Tribal Elders Program: |
| <input type="checkbox"/> Bishop Tribal Environmental Programs: |
| <input type="checkbox"/> Bishop Tribal Police: |
| <input type="checkbox"/> TANF: |
| <input type="checkbox"/> Bishop Tribal Family Formation Services: |
| <input type="checkbox"/> Bishop Tribal Social Services: |
| <input type="checkbox"/> Bishop Tribal ICWA: |
| <input type="checkbox"/> Bishop Tribal RAVE: |
| <input type="checkbox"/> Bishop Tribal LIHEAP: |
| <input type="checkbox"/> Bishop Tribal Child Care Services: |
| <input type="checkbox"/> Bishop Tribal Court: |
| <input type="checkbox"/> Bishop Tribal Public Works: |
| <input type="checkbox"/> Bishop Tribal TERO: |



- Bishop Tribal Enrollment:
- Bishop Tribal Food Sovereignty Program:
- Tuniwa Nobi Family Literacy:
- Nüümü Yadoha (Language Program)
- Cerro Coso:
- TIHP-Family Services:
- TIHP-Medical:
- TIHP-Dental:
- TIHP-Dialysis:
- TIHP-Prevention Programs:
- TIHP-WIC:
- Inyo County First 5:
- Inyo County Community Health:
- Inyo County Law Enforcement:
- Inyo County Fire Department:
- Wild Iris:
- Salvation Army:
- Inyo County Superintendent of Schools:
- Inyo County Child protective Services:
- Food Banks:
- IMACA Services:
- Other:
- Other
- Other:

What do you think are the greatest needs in your Community?
What other additional services do you feel is needed in your community?

Updated 1/27/2020

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