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?*** | |
| ❑ Parent working or in (college/vocational) | ❑ Parent not working or in (college/vocational) |
| ❑ Guardian working or in (college/vocational) | ❑ Guardian not working or in (college/vocational) |
| ❑ Grandparent working or in (college/vocational) | ❑ Grandparent not working or in (college/vocational) |
| ❑ Teen Parent working or in (college/vocational) | ❑ Teen Parent not working or in (college/vocational) |
| ❑ Foster Parent or in (college/vocational) | ❑ Foster Parent not or in (college/vocational) |
| ❑ None of the above. Please describe:________________________________________________ | |
| ***2. Your gender*** | |
| ❑Male | ❑ Female |

| ***3. Your age*** | | |
|---|---|---|
| ❑ 17 and under | ❑ 18-25 | ❑ 26-35 |
| ❑ 36-45 | ❑ 46-55 | ❑ 56 and Over |
| ***4. Your ethnicity/race (check all that apply)*** | | |
| ❑ Native American/Alaskan | ❑ African American | ❑ Caucasian |
| ❑ Hispanic | ❑ Asian/Pacific | ❑ Other________________ |
| ***5. What is the primary language spoken in your home? (check all that apply)*** | | |
| ❑ Paiute | ❑ English | ❑ Spanish |
| ❑ Other | ❑ Other | ❑ Other |

| ***6. Is anyone in your household a Head Start graduate? (check all that apply)*** | | | |
|---|---|---|---|
| ❑ Yourself | ❑ Spouse | ❑ Other children in family | ❑ None |

| **Tell Us about Your Family** | |
|---|---|
| ***7. What is your marital status?*** | |
| ❑ Single | ❑ Separated |
| ❑ Married | ❑ Living with my partner |
| ❑ Divorced | ❑ Widowed |
| ***8. Which of the following best describes your family? (Check only one)*** | |
| ❑ Two Parent Family | ❑ Female Head of Household, no husband |
| ❑ Male Head of Household, no wife | ❑ 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:*** | | |
| ❑ House, you own | ❑ Mobile, you own | ❑ Apartment (rent) |
| ❑ House, you rent | ❑ Mobile, you rent | ❑ Rent a room from other family |

| ***13. About your living situation, does your family live:*** | | |
|---|---|---|
| ❑ Alone as a family | ❑ With another family or person because of loss of housing or as a result of economic hardship (sometimes referred as "doubled-up") | |
| ❑ In a shelter | ❑ In a hotel/motel | ❑ 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?*** | |
| ❑ Yes, Type of insurance: | ❑ No, why not? |
| ***15. Does your family have access to affordable Dental Health Care Services?*** | |
| ❑ Yes, Type of insurance: | ❑ No, why not? |
| ***16. Does your family have access to affordable Mental Health Care Services?*** | |
| ❑ Yes, Type of insurance: | ❑ No, why not? |

| ***17. Where do you usually take your child to get medical care? (Check all that apply)*** | | |
|---|---|---|
| ❑ Family doctor | ❑ Community Health Clinic | ❑ Emergency room |
| ❑ Family dentist | ❑ Indian Health Service | ❑ 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)*** | |
|---|---|
| ❑ Decrease cost | ❑ Provide transportation |
| ❑ Increase the number of health centers | ❑ Provide more information about available health care |
| ❑ Other | ❑ Other |

| **Tell Us about Your Transportation** | | |
|---|---|---|
| ***19. How does your family get your child(ren)to school or childcare?*** | | |
| ❑ Car | ❑ Head Start transportation | ❑ Bike |
| ❑ Ride with a friend | ❑ Public transportation | ❑ Walk, How many miles |

| ***20. Do you have a reliable car?*** | |
|---|---|
| ❑ No | ❑ Yes, car is reliable |
| ***21. Would you like to see improvement to any of the following on the reservation?*** | |
| ❑ Sidewalks around Educational Services | ❑ 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** |
| ❑ | Not employed | ❑ |
| ❑ | Employed, full-time | ❑ |
| ❑ | Employed, part-time | ❑ |

| **Tell Us about Your Child Care Needs** | |
|---|---|
| ***23. Do you need child care for your child(ren) on a regular basis?*** | |
| ❑ Yes | ❑ No |

| ***24. What type(s) of child care are you currently using? (Check all that apply)*** | | |
|---|---|---|
| ❑ Older siblings | ❑ Relatives | ❑ Babysitter in the home |
| ❑ Licensed Family Child Care | ❑ Licensed Child Care Center | ❑ Head Start/Early Head Start |
| ***25. What was the main factor that influenced your decision about the child care arrangement you currently have? (Check all that apply)*** | | |
| ❑ Cost was affordable | ❑ Location near home or work | ❑ My child(ren) would be safe |
| ❑ Program has accreditation | ❑ Referral from family or friend | ❑ Other |

| ***26. What types of child care have you needed in the last 12 months? (Check all that apply)*** | | |
|---|---|---|
| ❑ Full-day care | ❑ Half-day care | ❑ Before/after school care |
| ❑ Night or weekend care | ❑ None | ❑ Other |
| ***25. Please check the periods that you most need child care during the week? (Check all that apply)*** | | |
| ❑ Mornings only | ❑ Evenings only | ❑ Weekends |
| ❑ Afternoons only | ❑ Highly varying hours and days | ❑ Other |
| ***26. How difficult is it for you to arrange back-up child care when your regular childcare arrangement doesn't work?*** | | |
| ❑ Very difficult | ❑ Somewhat difficult | ❑ Not at all difficult |
| ***27. How difficult is it for you to find child care for your child(ren) in the summer months when Head Start is not in session?*** | | |
| ❑ Very difficult | ❑ Somewhat difficult | ❑ Not at all difficult |

| **Tell Us about Your Income** | | | |
|---|---|---|---|
| ***28. What is your Source of Household Income? (Check all that apply)*** | | | |
| ❑ Full-time Employment | ❑ Self-Employed | ❑ TANF/Cal Works | ❑ Retirement |
| ❑ Part-time Employment | ❑ Seasonal Worker | ❑ SSI | ❑ Tribal Distribution/Per Cap |
| ❑ 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)*** | | | |
| ❑ Below Federal Poverty Guidelines | ❑ At Federal Poverty Guidelines | ❑ Above Federal Poverty Guidelines | |

| **2017 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** | **$12,060** |
| **2** | **$16,240** |
| **3** | **$20,420** |
| **4** | **$24,600** |
| **5** | **$28,780** |
| **6** | **$32,960** |
| **7** | **$37,140** |
| **8** | **$41,320** |

| **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** |
| ❑ | Some to no high school education | ❑ |
| ❑ | High School graduate/GED | ❑ |
| ❑ | Trade/Vocational School | ❑ |
| ❑ | Some College | ❑ |
| ❑ | AA degree (2-year degree) | ❑ |
| ❑ | Bachelor's degree | ❑ |
| ❑ | Some graduate school | ❑ |
| ❑ | Master's Degree | ❑ |
| ❑ | Doctorate Degree | ❑ |

| ***32. Are you or your spouse/partner currently in school? (Mark one for you and your spouse/partner)*** | | |
|---|---|---|
| **Yourself** | | **Spouse/Partner** |
| ❑ | No | ❑ |
| ❑ | Yes, full-time | ❑ |
| ❑ | Yes, part-time | ❑ |

## 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)*** | |
|---|---|
| ❑ Not aware of existing services | ❑ Services are too far away from home |
| ❑ Waiting list are too long | ❑ Agencies not open at convenient time |
| ❑ Child care is not available | ❑ Transportation |
| ❑ Agencies' fees are too high | ❑ Rules and eligibility exclude people |
| ❑ Agencies' staff are rude | ❑ Concerns about confidentiality |
| ❑ Uncomfortable with "outsiders" | ❑ None |

| ***34. Indicate if your family has any of the following needs (Check only those that apply to you and your family)*** | | |
|---|---|---|
| ❑ Education/Job Training | ❑ Employment Services | ❑ Vehicle repairs |
| ❑ Health Services | ❑ Budgeting income | ❑ Housing improvements |
| ❑ Dental Services | ❑ Emergency Rent | ❑ Domestic Violence Prevention |
| ❑ Mental Health Services | ❑ Transportation | ❑ Child Abuse Prevention |
| ❑ Nutrition Services | ❑ Parenting Workshops | ❑ Water/Sewer hook ups |
| ❑ Food | ❑ Heating Home | ❑ Electricity / Propane |
| ❑ Clothing | ❑ Cooling Home | ❑ 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?*** | |
|---|---|
| ❑ Friends/Relatives | ❑ Mental Health Office |
| ❑ Dental or Doctor Office | ❑ Head Start Staff |
| ❑ Head Start flyer or brochure | ❑ Early Head Start Staff |
| ❑ Bishop Tribal Radio | ❑ Other:______________ |
| ❑ Elementary School | ❑ Other:______________ |

| ***36. If you have volunteered at Head Start, please check all of the ways you have volunteered?*** | |
|---|---|
| ❑ Helping in the classroom | ❑ Helping with fieldtrips |
| ❑ Helping on the bus | ❑ Servicing on Center Parent Committee |
| ❑ Servicing on Policy Council | ❑ Servicing on Health/Nutrition Committee |
| ❑ Servicing on Education Committee | ❑ Translating, verbal or written |
| ❑ Special Projects | ❑ Special Events |

| ***37. Would you please tell us what program would best fit your needs?*** |
|---|
| ❑ Home based program with 1 home visit a week |
| ❑ Full day-full year program; five days a week; year-round (8:00 am-5:00pm) |
| ❑ Full day program; five days per week; 10 months a year (8:00 am-2:30pm) |
| ❑ Early Head Start (Infants and Toddlers) |

***38. If your child(ren) went to BIHS, please rate your experience:***

| **Please Check One:** | **Very Good** | **Good** | **Needs Improvement** | **Unacceptable** |
|---|---|---|---|---|
| Did Head Start assist in your child(ren)'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.*** | |
| ❑ Child Abuse & Neglect | ❑ Family Fitness |
| ❑ Child Growth & Development | ❑ Gardening |
| ❑ Parenting Skills | ❑ Volunteering in the Community |
| ❑ Continuing Education Training | ❑ Technical or Vocational Training |
| ❑ Dental Care | ❑ Self-Esteem |
| ❑ Domestic Violence | ❑ Substance Abuse |
| ❑ Employment Training | ❑ Domestic Violence |
| ❑ CPR & First Aid | ❑ Stress Management |
| ❑ Food Preparation | ❑ Health, Wellness & Hygiene |
| ❑ Time Management | ❑ Fire Prevention Training |
| ❑ Child Car Seat Safety | ❑ Computer Training |
| ❑ Program Governance | ❑ Money Management |
| ❑ Challenging Behavior | ❑ Elder Care |
| ❑ Nutrition | ❑ Other |
| ❑ Navigating through Community Resources | ❑ Other |

| ***41. Please tell us what Community Services on or off the Reservation you have used and your experience with those services? Please See Page 6.*** |
|---|
| ❑ Hüübü program: |
| ❑ OVCDC Early Head Start: |
| ❑ Bishop Indian Head Start: |
| ❑ Bishop Tribal Education Center: |
| ❑ Bishop Tribal Youth Activities: |
| ❑ OVCDC College and Career Counseling: |
| ❑ OVCDC Student Services: |
| ❑ Bishop Tribal Elders Program: |
| ❑ Bishop Tribal Environmental Programs: |
| ❑ Bishop Tribal Police: |
| ❑ TANF: |
| ❑ Bishop Tribal Family Formation Services: |
| ❑ Bishop Tribal Social Services: |
| ❑ Bishop Tribal ICWA: |
| ❑ Bishop Tribal RAVE: |
| ❑ Bishop Tribal LYHEAP: |
| ❑ Bishop Tribal Child Care Services: |
| ❑ Bishop Tribal Court: |
| ❑ Bishop Tribal Public Works: |
| ❑ 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:

Additional Resources Available in your Community:

| | |
|---|---|
| Legal Problems | RAVE and Inyo County Self-Help Center |
| Incarcerated Individuals | Inyo County Re-Entry Coordinator |
| Child Abuse | BPT Socials Services |
| Child Care Needs | BPT Socials Services |
| Homeless & Shelter & Safety Needs | BPT Socials Services |
| Parenting Education | BPT Socials Services |
| Mental/Social/Emotional Health | Family Services, North Star Counseling |
| Community Involvement | OVCDC |
| Chemical Dependency/Substance Abuse | Family Services, Local AA, Local NA |

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

Example: Spirituality

**Updated 3/9/2017**

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