

Transition Survey for Graduates of the Kentucky Commission for Children with Special Health Care Needs

First, I have some questions about your health care now:

1. Do you have a family doctor or clinic that you go to when you are sick or need a checkup?

YES NO

IF YES: Doctor/clinic name _____

How often have you been to your family doctor or clinic in the past year?

- not at all
 once
 every 6 months (about 2 times per year)
 every 3 months (about 4 times per year)
 monthly (about 12 times per year)
 more than monthly
 don't know

IF NO family doctor, if you had a sore throat and a high fever, where would you go for healthcare?

- Emergency Room
 Local walk-in clinic
 Other _____

2. Do you have doctors for your specialty care such as orthopedics or a heart condition?

YES NO If Yes, Name _____

IF YES, how often have you been to your specialists in the past year?

- not at all
 once
 every 6 months (about 2 times per year)
 every 3 months (about 4 times per year)
 monthly (about 12 times per year)
 more than monthly
 don't know

3. Have you gone to an emergency room this past year? YES NO

IF YES, how many times? _____ For what? _____

4. Have you stayed IN the hospital in the past year? YES NO

IF YES, how many times? _____ How many days? _____

What for? _____

5. How do you pay for your medical care? Do you have:
- Medical Card/Medicaid
 - private insurance through your job - name of insurer _____
 - insurance through a family member - name _____
 - insurance offered by your college or university
 - other insurance such as Medicare, CHAMPUS – name _____
 - don't have insurance, so you pay out of pocket
 - some other individual pays for you - who _____
 - don't know
6. If you have health insurance, does it cover your needs?
- YES NO If NO, what is not covered? _____
 - No insurance
7. Are you taking any medications? YES NO
- IF YES, how do you pay for them?
- Medical Card/Medicaid
 - private insurance Copayment? \$ _____
 - pay out of pocket
 - someone else pays for me
 - don't know
8. When was the last time you visited a dentist?
- Within the last 6 months
 - 6 to 12 months ago
 - 1 to 2 years ago
 - more than 2 years ago
 - never
 - don't know

Next, I have some questions about your health in general:

9. In general, would you say your health is
- Excellent
 - Very Good
 - Good
 - Fair
 - Poor

10. Compared to one year ago, how would you rate your health in general now:

- Better than 1 year ago
- About the same as 1 year ago
- Worse than 1 year ago
- Don't know

11. In the next few years, how do you expect your health will be compared to now:

- Better than now
- About the same as now
- Worse than now
- Don't know

Which of the following best describe your diagnoses or long-term condition(s)?
(check all that apply)

- Asthma
- Blind or vision impaired or other eye problems
Do you wear glasses? YES NO
- Burns
- Cerebral Palsy
- Cleft Lip and Palate
- Craniofacial Abnormalities
- Cystic Fibrosis
- Deaf or hearing impaired Do you wear a hearing aid? YES NO
- Diabetes or metabolic/endocrine
- Epilepsy/seizure disorder
- Heart defect or condition
- Hemophilia/bleeding disorders
- Juvenile Rheumatoid Arthritis
- Muscular Dystrophy
- Neurological problem
- Orthopedic (club foot, limb problems, etc.)
- Scoliosis
- Sickle Cell
- Spina Bifida
- Spinal cord injury
- Surgery for _____
- Attention deficit disorder (ADHD)
- Mentally handicapped
- Impaired ability to speak
- Emotional/mental health problem
- Other _____
- I don't have a long-term condition

Next I have some questions about school and work:

12. Are you in school now? YES NO

IF YES, what grade or level: _____

- high school
- technical school
- community college
- 4-year college
- other _____

IF NO, what was the last grade of school that you completed? _____

In school, did you or do you now participate in clubs, sports, leadership, or other activities outside of classes? YES NO

Were you or are you now in any special program in school?

- accelerated
- independent study
- special education
- home school
- other _____

Have you completed training outside of school? YES NO

If yes, what type _____

13. Do you have plans to get more schooling in the next few years?

- YES NO Don't know

IF YES: Type _____

14. Do you use a computer? YES NO

IF YES, do you (check all that apply)

- play computer games
- use e-mail
- surf the internet
- do computer graphics like web page design
- do word processing
- do data analysis or use spreadsheets
- use a computer for communication (i.e. speech synthesizer)

Where do you use the computer?

- Home Library
- School Work
- Other _____

15. Are you working now?
 NO (Continue below) YES (Please go to Question 16)

IF NO, would you like to work? YES NO

IF YES, what would help you be able to work?

- transportation
- technology
- education
- special kind of job
- help with family responsibilities
- be sure I have health insurance
- not enough energy to work
- get over my fears of working
- my parents have to let go
- other _____

Are you actively looking for a job now? YES NO

What type of work are you looking for? _____

What pay do you hope to get? _____

*****If not working, please SKIP TO QUESTION 22, top of Page 7 *****

16. IF you are working now, what is your job title or what do you do at work?

Over the past year, on average, how many hours have you worked per week _____

Do you work the same amount each week or does it vary a lot from week to week? Same Varies from _____ to _____ hours/week.

17. Over the past year, on average, how much have you earned per week before taxes? \$ _____ per _____
(may give hourly or per pay period—we can convert)

18. How long have you worked at your current job?
- 0-6 months
 - 6-12 months
 - 1 -2 years
 - more than 2 years

19. Does your employer do anything special to help you out so you can work, such as: (check all that apply)
- Get someone to help you
 - Shorten your work day
 - Allow you to change the time you come to or leave work
 - Allow you more breaks and rest periods
 - Arrange for special transportation
 - Change the job to something you could do
 - Help you learn new skills
 - Get you special equipment for the job
- IF checked What? _____
- No need for anything special
 - Don't know

20. Would you like to do a different kind of work within the next 5 years?
- YES NO Don't know
- IF YES What? _____

Are you doing anything now to make this possible? YES NO

If yes, what? _____

21. Are you offered health insurance with your job: YES NO

IF YES, Did you take the health insurance? YES NO

IF you did NOT take the insurance, was it:

- because you are covered by a family member's insurance
- have insurance through a public program such as Medicaid
- it is too expensive
- other _____

IF you are NOT offered health insurance: Is it because

- You work part-time
- No one at the place has health benefits
- Not eligible because of pre-existing conditions
- Other _____

*****If you are not working, please start here again;
if you are working, please continue with question 22*****

22. Do you get an SSI check? NO YES If YES, how much? \$ _____
 IF YES, Do you know about social security work incentives, like a PASS plan where you can set aside money for transportation, car modification, or personal assistance? YES NO
 IF YES, have you used any of these work incentives? YES NO

23. About how much money do you get each month from all sources?
 Is it:
 Less than \$500 per month (less than \$6000 per year)
 Between \$500 and \$1000 per month (between \$6000 and \$12,000 per year)
 Between \$1000 and \$1500 (between \$12,000 and \$18,000 per year)
 Between \$1500 and \$2000 per month (between \$18,000 and \$24,000 per year)
 Between \$2000 and \$4000 per month (between \$24,000 and \$48,000 per year)
 Over \$4,000 per month (over \$48,000 per year)
 Parent or family support (for example, live with parents or they help with expenses)
 Other _____
 Don't know

Do you manage your own money? YES NO

24. Have you worked with any of these community agencies?
- | <u>AGENCY</u> | <u>Worked With?</u> | <u>HELPFUL?</u> |
|--------------------------------|--|--|
| Vocational Rehabilitation | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Centers for Independent Living | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| Support groups | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Next, I have some questions about transportation and living arrangements.

25. Do you drive? YES NO
 IF YES, Do you have your own vehicle? YES NO
 IF YES, Has it been modified for you to drive? YES NO
- What is your typical source of transportation for day-to-day activities?
 You drive a car/truck Bus Moped or motorcycle
 Cab Bike Walk
 Ride with friend or family member in their vehicle
 Other _____

26. Who do you live with?

- parents
- husband/wife or boyfriend/girlfriend
- children
- other family such as grandparents, brother, sister, aunt, uncle
- friends in house or apartment
- dormitory
- alone
- other _____

Are you: single married divorced separated

Do you have children? YES NO IF YES, how many _____

27. How do you do each of the following? (please check the box that best describes how you do these things)

Activity	Alone	With a little help	With a lot of help
Walking/moving around Use wheelchair Yes <input type="checkbox"/>			
Transferring (like from a chair to a bench)			
Communicating/talking			
Writing			
Grooming (such as bathing, dressing)			
Daily health care procedures No procedures <input type="checkbox"/>			
Using special equipment Do not use any <input type="checkbox"/>			
Taking medications Do not take any <input type="checkbox"/>			
Knowing when you are healthy or getting sick			

Does your condition affect how you function:

- | | | | |
|------------------------------------|-------------------------------------|-------------------------------|--------------------------------|
| At school? | Not at all <input type="checkbox"/> | Some <input type="checkbox"/> | A lot <input type="checkbox"/> |
| At work? | Not at all <input type="checkbox"/> | Some <input type="checkbox"/> | A lot <input type="checkbox"/> |
| In social/recreational activities? | Not at all <input type="checkbox"/> | Some <input type="checkbox"/> | A lot <input type="checkbox"/> |

28. Here is a list of some things people do. Please check if you do these things a lot, sometimes, not much, or never.

Activity	A Lot	Some-times	Not Much	Never
Talk with friends on the phone				
See friends someplace outside your home				
Go grocery shopping				
Cook meals				
Do laundry				
Work in the yard or do odd jobs, like repair the car or house				
Go to church				
Go to sports events, movies, concerts				
Play sports or work with sports team				
Play a musical instrument or do artistic things				
Go hunting or fishing				
Watch TV				
Read				
Smoke cigarettes				
Chew tobacco				
Exercise				
Drink alcohol				
Feel sad, lonely, or depressed				
Other:				

Lastly, I have some questions about your family, life as you were growing up, and your experience with the Commission.

29. Did you have chores to do at home when you were growing up like washing dishes, collecting trash, feeding a pet? YES NO

30. When you were growing up did you do volunteer work? YES NO

Did you have a job for pay? YES NO

31. Did your family expect you to graduate from high school?

YES NO

If YES, did they expect you to continue in technical school or college?

YES NO

32. Did your family expect you to work? YES NO

33. What did your family members do for a living while you were growing up?

34. Does either your mother or your father have a disability? YES NO

How many years of schooling does your mother have? _____

How many years of schooling does your father have? _____

35. Does anyone in your house get SSI? YES NO
IF YES, who?

36. Did anyone at the Commission refer you to doctors or clinics that care for adults?
 YES NO IF YES, where?

Did you need help in finding adult health care? YES NO
Did you get your records when you were discharged? YES NO

37. Did anyone at the Commission refer you to agencies that help with getting a job?
 YES NO
IF YES, where?

38. Is there anything you wish the Commission might have done differently to help you?

39. Did someone help you complete this survey? YES NO
Your Age _____ Male Female
Your Race/Ethnic background _____

40. Do you have any other comments?

This is the end of the survey. Thank you very much for completing it. This information will help us to plan services for children at the Commission. When we receive your survey we will send you coupons for free fast food. Please complete the attached coupon request form and return it with your survey in the postage-paid envelope. Thanks again!