



2021 COMMUNITY HEALTH NEEDS ASSESSMENT SURVEY

Health and wellness matters to everyone. That's why Penn Medicine Princeton Health wants to know how health and wellness programs and services can best serve area residents, and we want you to be part of that planning. We recognize this is a unique time we are in. We would like to understand what issues have personally affected you and your family now and prior to the COVID-19 pandemic.

We are asking people who live or work in the communities in Somerset, Mercer, and Middlesex Counties to give us your feedback and suggestions about health services and issues in the region by completing this 10-15 minute survey by **Friday, June 4, 2021**. All responses are completely anonymous. There are no right or wrong answers; it's your opinion that matters!

Your feedback is valuable since the information gathered from this survey will be used to inform future health programming and services in this region.

Thank you for your participation.

What To Do When You're Done. Once you complete the survey, please mail it to:

Debbie Millar and Craig Harley
Penn Medicine Princeton Health
731 Alexander Road, Suite 103
Princeton, NJ 08540

1. What is the zip code where you live? ____ _
2. What is the zip code where you work, volunteer, worship, or go to school (if applicable)? (If more than one applies, then indicate the zip code where you work.) ____ _

Community Health

We recognize this is a unique time we are in. We would like to understand what issues have personally affected you and your family now and prior to the COVID-19 pandemic.

3. For each health issue, please check if the issue was something that affected you or your family personally now and/or prior to COVID - or has not affected you or your family at either time period. You can check any that apply.

	Currently affects me or my family	Affected me or my family prior to COVID	Does not affect me or my family now nor prior to COVID
Access to health care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to healthy foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Access to affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aging health concerns (e.g., Alzheimer's, dementia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving (e.g., elder care, childcare)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's health concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic disease (e.g., diabetes, heart disease, hypertension)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Community violence (e.g., gangs, street crime)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus/COVID-19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental and oral health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environmental health issues (e.g., lead poisoning, air pollution, climate change)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Infectious/contagious disease other than COVID-19, like tuberculosis, pertussis, pneumonia, flu, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Injuries (e.g., car accidents, falls, concussion)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal violence (e.g., domestic violence, sexual violence, bullying)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ health concerns	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental health issues (e.g. anxiety, depression, suicide)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal issues (e.g. joint pain, arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neuroscience issues (e.g. epilepsy, seizures)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Overweight or obesity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted infections (e.g., HIV/AIDS, chlamydia, gonorrhea)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Substance use disorder (e.g., heroin, other opioids, marijuana, cocaine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Currently affects me or my family	Affected me or my family prior to COVID	Does not affect me or my family now nor prior to COVID
Women's health issues (e.g., reproductive health, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. Please select the **TOP 5 HEALTH ISSUES** impacting you or your family personally and the community in which you live. Please select 5 health issues FOR EACH column below. You can select the same or different issues for each.

	You/Your family	Community where you live
Access to health care services	<input type="checkbox"/>	<input type="checkbox"/>
Access to healthy foods	<input type="checkbox"/>	<input type="checkbox"/>
Access to affordable housing	<input type="checkbox"/>	<input type="checkbox"/>
Aging health concerns (e.g., Alzheimer's, dementia)	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol use disorder	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Caregiving (e.g., elder care, childcare)	<input type="checkbox"/>	<input type="checkbox"/>
Children's health concerns	<input type="checkbox"/>	<input type="checkbox"/>
Chronic disease (e.g., diabetes, heart disease, hypertension)	<input type="checkbox"/>	<input type="checkbox"/>
Community violence (e.g., gangs, street crime)	<input type="checkbox"/>	<input type="checkbox"/>
Coronavirus/COVID-19	<input type="checkbox"/>	<input type="checkbox"/>
Dental and oral health	<input type="checkbox"/>	<input type="checkbox"/>
Environmental health issues (e.g., lead poisoning, air pollution, climate change)	<input type="checkbox"/>	<input type="checkbox"/>
Infectious/contagious disease other than COVID-19, like tuberculosis, pertussis, pneumonia, flu, etc.	<input type="checkbox"/>	<input type="checkbox"/>
Injuries (e.g. car accidents, falls, concussion)	<input type="checkbox"/>	<input type="checkbox"/>
Interpersonal violence (e.g., domestic violence, sexual violence, bullying)	<input type="checkbox"/>	<input type="checkbox"/>
LGBTQ health concerns	<input type="checkbox"/>	<input type="checkbox"/>
Mental health issues (e.g., anxiety, depression, suicide)	<input type="checkbox"/>	<input type="checkbox"/>
Musculoskeletal issues (e.g., joint pain, arthritis)	<input type="checkbox"/>	<input type="checkbox"/>
Neuroscience issues (e.g., epilepsy, seizures)	<input type="checkbox"/>	<input type="checkbox"/>
Overweight or obesity	<input type="checkbox"/>	<input type="checkbox"/>
Sexually transmitted infections (e.g., HIV/AIDS, chlamydia, gonorrhea)	<input type="checkbox"/>	<input type="checkbox"/>
Substance use disorder (e.g., heroin, other opioids, marijuana, cocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Unintended pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Women's health issues (e.g., reproductive health, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>

5. In general, how would you describe the overall health of the following currently ?

	Excellent	Very Good	Good	Fair	Poor
The community in which you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The community in which you work, volunteer, worship, or go to school (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. In general, how would you describe the overall health of the following before COVID?

	Excellent	Very Good	Good	Fair	Poor
The community in which you live	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The community in which you work, volunteer, worship, or go to school (if applicable)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. What do you see as the strengths of your community? (Please check all that apply.)

- ☐ My community is close to medical services
- ☐ My community has good access to resources
- ☐ My community has people of many races and cultures
- ☐ People speak my language
- ☐ People accept others who are different than themselves
- ☐ People care about improving their community
- ☐ People are proud of their community
- ☐ People feel like they belong in this community
- ☐ People like to work together in this community
- ☐ People can deal with challenges in this community
- ☐ There are innovation and new ideas in my community
- ☐ None of the above

Access to Services

8. Please think about the different health care services in your community. In general, how easy or hard is it to access the following health care services in your community?

	Very easy	Easy	Not easy or hard	Hard	Very hard	Don't know
Alcohol or drug treatment or prevention services for adults (age 18+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or drug treatment or prevention services for youth (under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer care/treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/mental health care for adults (age 18+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling/mental health care for children or adolescents (under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental or oral health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency department services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Very easy	Easy	Not easy or hard	Hard	Very hard	Don't know
Health or medical services for children or adolescents (under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health or medical services for seniors (age 65+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health or medical services for women (e.g. reproductive health, pregnancy, breast health, pelvic health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immunizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occupational therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Outpatient services such as lab work or radiology (e.g. X-rays, MRIs)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Primary care physicians	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specialty care (e.g. gastroenterologist, cardiologist, endocrinologist, nephrologist, neurologist, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Urgent care services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. When trying to get medical care, how often have YOU PERSONALLY felt discriminated against based on any of the following characteristics:

	Frequently	Sometimes	Never
Your race or ethnicity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your cultural or religious background	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your language	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your income	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your body size	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your sexual orientation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your gender or gender identity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Your disability (if not applicable, select "Never")	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

10. Have any of these issues made it difficult for you to get needed health services within the last two years? (Please check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> Lack of transportation | <input type="checkbox"/> Cost of care (e.g., deductibles, co-pays) |
| <input type="checkbox"/> No provider available near me/services not available in my community | <input type="checkbox"/> Cost of prescription medications |
| <input type="checkbox"/> Lack of information/ I don't know what types of services are available | <input type="checkbox"/> Language problems/could not communicate with health provider or office staff |
| <input type="checkbox"/> Office not accepting new patients | <input type="checkbox"/> Unfriendly provider or office staff |
| <input type="checkbox"/> Lack of evening or weekend services | <input type="checkbox"/> Afraid to have health check-up |
| <input type="checkbox"/> Long wait for an appointment | <input type="checkbox"/> Afraid due to immigration status |
| <input type="checkbox"/> Lack of specialists/specialty care services | <input type="checkbox"/> I have never experienced any difficulty in getting care |
| <input type="checkbox"/> Insurance problems/lack of coverage | |

Community Priorities

11. Please check whether you consider these issues to be low, medium, or high priority for future funding and resources in your community.

	Low	Medium	High
Increasing transportation to area health/medical services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing the health/medical services that are close by and easy to get to	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing more language interpretation services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing the number of providers/staff that speak languages other than English	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding programs or services designed to help patients navigate the health care system	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing more counseling or mental health services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Providing more alcohol or drug prevention and treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding cancer screening, diagnostics, and treatment services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding the health/medical services focused on seniors (65+)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing the number of services to help the elderly stay in their homes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding the health/medical services focused on children and adolescents (under 18 years)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding the health/medical services focused on women's health issues (e.g., pregnancy, well-visits, pelvic health)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding the health/medical services available to low-income individuals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expanding access to technology that can help me to monitor and maintain my health (e.g., health apps for smartphones)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering community education programs on the environment and environmental sustainability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering more programs or services focusing on physical activity and/or nutrition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering more programs or services focusing on obesity/weight control	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering more programs or services focusing on prevention of chronic diseases like heart disease or diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering more programs or services focusing on wellness like meditation, yoga, acupuncture, or mindfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Offering more programs or services to help people quit smoking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing access to affordable housing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing availability of sidewalks or parks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing availability of supermarkets/healthy food options people can afford	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing the availability of safe, stable, quality, well-compensated work for all people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Increasing the quality of educational opportunities for all people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Health Coverage and Information

12. Are you personally currently covered by any of the following types of health insurance or health coverage plans? (Check all that apply)

- ☐ Insurance through a current or former employer or union (yours or another family member's)
- ☐ Insurance purchased directly from an insurance company (by you or another family member) including coverage purchased through a healthcare exchange or marketplace such as Healthcare.gov, otherwise called 'Obamacare'
- ☐ Medicare, for people age 65 and older, or people with certain disabilities
- ☐ Medicaid, Medical Assistance (MA), the Children's Health Insurance Program (CHIP) or any kind of state or government-sponsored assistance plan based on income or a disability. You may know this type of coverage as 'NJ Family Care'
- ☐ Tricare or other military health care, including Veteran's Administration health care
- ☐ Any other type of health insurance coverage or health coverage plan
- ☐ No insurance, uninsured

13. What is your MAIN SOURCE of medical care? (Please check one.)

- ☐ Private doctor's office or group practice
- ☐ Community health center (i.e. Clinic)
- ☐ Emergency Room at a hospital
- ☐ Walk-in medical clinic/urgent care center
- ☐ Free medical program
- ☐ Veteran's Administration facility
- ☐ Tele-health or tele-medicine services (i.e. health services or consultations delivered via remote video link)
- ☐ Do not have a main source of medical care
- ☐ Other (please specify): _____

14. Have you ever used an online patient portal (like Princeton HealthConnect) to securely access your own or a family member's medical record, lab or radiology reports, medication lists, or other information about health care services received?

- ☐ Yes
- ☐ No
- ☐ Don't know/Not sure

15. Have you ever used your mobile device (e.g., smartphone) to access health care for yourself or a family member, for example by video-conferencing or virtually chatting with your health care provider?

- ☐ Yes (GO TO Q17)
- ☐ No
- ☐ Don't know/Not sure

16. (IF YOU ANSWERED "YES" IN Q15, SKIP TO Q17) Would you be interested in accessing health care for yourself or a family member through your mobile device or smartphone (for example, video-conferencing or virtually chatting with your health care provider)?

- ☐ Yes
- ☐ No

Demographic Information

These few last questions are so we can see the range of people who will be answering this survey. Like your other answers, these answers will remain anonymous.

17. What category best describes your age?

- | | |
|---|--|
| <input type="checkbox"/> Under 18 years old | <input type="checkbox"/> 50-64 years old |
| <input type="checkbox"/> 18-29 years old | <input type="checkbox"/> 65-74 years old |
| <input type="checkbox"/> 30-39 years old | <input type="checkbox"/> 75 years old or older |
| <input type="checkbox"/> 40-49 years old | |

18. What is your gender?

- | | |
|---|---|
| <input type="checkbox"/> Male | <input type="checkbox"/> Transgender Female |
| <input type="checkbox"/> Female | <input type="checkbox"/> Gender neutral |
| <input type="checkbox"/> Transgender Male | <input type="checkbox"/> Additional Gender Category |

19. How would you describe your ethnic/racial background? (Please check all that apply.)

- | | |
|---|---|
| <input type="checkbox"/> African American/Black | <input type="checkbox"/> Caucasian/White |
| <input type="checkbox"/> East Asian/Pacific Islander (e.g., Japan, China, Taiwan, Korea, Vietnam, Laos, Cambodia, the Philippines, Samoa) | <input type="checkbox"/> Hispanic/Latino(a) |
| <input type="checkbox"/> South Asian (e.g., India, Pakistan, Bangladesh, Sri Lanka, Nepal) | <input type="checkbox"/> Middle Eastern/North African |
| | <input type="checkbox"/> American Indian/Native American |
| | <input type="checkbox"/> Additional ethnic/racial category (please specify):
_____ |

20. What is the primary language you speak at home?

- | | |
|---|--|
| <input type="checkbox"/> English | <input type="checkbox"/> Hindi |
| <input type="checkbox"/> Spanish | <input type="checkbox"/> Telugu |
| <input type="checkbox"/> Chinese (including Mandarin and Cantonese) | <input type="checkbox"/> Nepali/Marathi/Konkani |
| <input type="checkbox"/> Portuguese / Cape Verdean Creole | <input type="checkbox"/> Polish |
| <input type="checkbox"/> Haitian | <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Arabic |
| <input type="checkbox"/> Cambodian/Khmer | <input type="checkbox"/> Korean |
| <input type="checkbox"/> French (including Cajun) | <input type="checkbox"/> Russian |
| <input type="checkbox"/> Tagalog/Filipino | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> Gujarati | |

21. What is the highest level of education that you have completed?

- | | |
|--|--|
| <input type="checkbox"/> Primary or middle school | <input type="checkbox"/> Associate or technical degree/certification |
| <input type="checkbox"/> Some high school | <input type="checkbox"/> College graduate |
| <input type="checkbox"/> High school graduate or GED | <input type="checkbox"/> Graduate or professional degree |
| <input type="checkbox"/> Some college | |

22. Are you the parent of a child under the age of 18? ☐ Yes ☐ No

Thank you for taking this survey! Results will be made available to the community in Fall 2021.