

**Citywide Advisory Board  
Health Needs Planning Committee  
Questionnaire Project  
c/o Fort DuPont Resident Council  
24 Ridge Road, SE  
Washington, DC 20019**

Dear Fellow Public Housing Resident:

Enclosed, you will please find a questionnaire that we hope you will complete. The questionnaire is historic. It is the first time that a survey has been developed by public housing residents themselves through a city-wide collaboration, the Public Housing Citywide Advisory Board Health Needs Planning Committee, to determine the health status of individuals and families living in public housing in the District.

In addition to public housing residents, organizations including the DC Department of Health, Unity Healthcare, Inc., the United Medical Center, Children's National Medical Center and the DC Housing Authority, to name a few, also helped to develop the questionnaire.

Good health requires us to act on facts we learn about ourselves. The questionnaire does just that; it gives us the facts as only we know them. When you return the completed questionnaire to the collection box on your property, the information will be used to plan and implement useful health and wellness activities that will benefit you and your families. Please put the completed questionnaire in the designated collection box in the management office that serves your property. **Do not put your name anywhere on the form.** If you have questions, please feel free to contact Kenneth Council at (202) 575-3601. Thank you very much for your cooperation.

Sincerely,

A handwritten signature in black ink that reads "Kenneth D. Council". The signature is written in a cursive, flowing style.

**Angelia Scott, President  
Kenneth Council, Vice President  
Citywide Advisory Board**

Enclosure

## DC Public Housing- Building Healthier Communities



We are constantly working to deliver the best services possible to our community. Please help us serve you better by taking a few minutes to tell us about you and your community and what type of services you have received. The goal of this survey is to improve our services to you. Your participation is completely voluntary - your housing and your ability to receive health care will not be affected if you choose to participate or choose not to participate in this survey. ***This survey is anonymous, please DO NOT PUT YOUR NAME ANYWHERE ON THE PAPER. However, please provide the name of your property, so that we can properly identify what services residents want on their specific property. Thank you for your help!***

Property Name: \_\_\_\_\_

1) What are the most important issues affecting the health of your community?

(Check up to 3 issues)

- Hunger ( not enough food )
- Healthy Foods (not available/ can't afford)
- Violence ( domestic violence, child or senior abuse)
- Recreation ( safe places to play/exercise)
- Number of liquor stores
- Condition of housing ( lead, lighting, elevators, stairs, pests, heating/cooling)
- Public Safety ( illegal drug sales, gangs, shootings)
- Concerns about clean air and water
- Health Care

2) What are the most important health issues and concerns for you and your family?

- |  |  |
|--|--|
| <input type="checkbox"/> Alcohol & Drug Abuse  | <input type="checkbox"/> High Cholesterol                      |
| <input type="checkbox"/> Allergies   | <input type="checkbox"/> HIV/AIDS                              |
| <input type="checkbox"/> Arthritis   | <input type="checkbox"/> Infant and Child Health               |
| <input type="checkbox"/> Asthma  | <input type="checkbox"/> Kidney Disease                        |
| <input type="checkbox"/> Brain Injury  | <input type="checkbox"/> Mental Health                         |
| <input type="checkbox"/> Cancer. What type? _____  | <input type="checkbox"/> Overweight/Obesity                    |
| <input type="checkbox"/> Cold & Flu  | <input type="checkbox"/> Pregnancy Care                        |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) & other breathing conditions | <input type="checkbox"/> Sexually -transmitted Diseases        |
| <input type="checkbox"/> Dental/Oral Health Care   | <input type="checkbox"/> Stress                                |
| <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Stroke                                |
| <input type="checkbox"/> Eye Care  | <input type="checkbox"/> Tobacco Use                           |
| <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Other _____                           |
|  | <input type="checkbox"/> Go to the emergency room or hospital? |
|  | <input type="checkbox"/> Other _____                           |

3) What do you do when you or a family member has a serious medical need?

- Go to my own doctor or health center

-For Office Use Only-

Property Code \_\_\_\_\_

4) Thinking about convenience versus privacy issues, what would be the best location for a Health Center?

- Mobile Van
- Health Center in or near Management Office.
- In one of the housing units on the property
- Nearby, but offsite of the housing complex

5) What would be the best hours of operation for a health center located in this community?

Monday	<input type="checkbox"/> 9am – 12pm	<input type="checkbox"/> 1pm – 5pm	<input type="checkbox"/> 5pm– 8pm
Tuesday	<input type="checkbox"/> 9am – 12pm	<input type="checkbox"/> 1pm – 5pm	<input type="checkbox"/> 5pm– 8pm
Wednesday	<input type="checkbox"/> 9am – 12pm	<input type="checkbox"/> 1pm – 5pm	<input type="checkbox"/> 5pm– 8pm
Thursday	<input type="checkbox"/> 9am – 12pm	<input type="checkbox"/> 1pm – 5pm	<input type="checkbox"/> 5pm– 8pm
Friday	<input type="checkbox"/> 9am – 12pm	<input type="checkbox"/> 1pm – 5pm	<input type="checkbox"/> 5pm– 8pm

6) Are you concerned about second-hand smoke in your building or apartment?

- Very concerned
- Somewhat concerned
- Not concerned

7) Would you like your housing property to become non-smoking?

- Yes
- No
- I Don't Know
- I would like more information

8) What types of recreation/physical activities would you like to see in your community for yourself?

- Walking clubs
  - Sports
  - Hand- dancing
  - Exercise classes
  - Cooking classes
  - Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

9) What types of recreation/physical activities would you like to see in your community for your family?

- Walking clubs
  - Sports
  - Hand- dancing
  - Exercise classes
  - Cooking classes
  - Other \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

10)	What is the age of:	What is your race? Please write in one: AI/AN, Black, Asian, NH/PI, White**	Are you Hispanic or Latino?	Do you have health insurance?	Do you have your own doctor?	Do you have your own dentist?
Head of Household			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Household Member 1			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Household Member 2			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Household Member 3			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Household Member 4			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Additional Household Member 5			<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

\*\*American Indian or Alaska Native Asian = AI/AN; Black or African American = Black; Native Hawaiian or other Pacific Islander= NH/PI

11) Additional Comments:

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Thank you for your participation!