

## Instructions: Income and Affordability Survey for BC Seniors

This survey will be used to assist the Office of the Seniors Advocate to better understand some of the financial challenges faced by BC seniors. This survey is estimated to take 20 to 30 minutes to complete, and respondents are only expected to provide their best guess or estimate in their response.

- For each question, please mark your choice with a blue or black pen by making a check in the square as follows:
- There are no right or wrong answers – just your views and opinions. You are free to skip any questions that you do not want to answer.
- You may receive assistance from a family member or friend to complete this survey, but it is **your** experience we want to hear about.
- Please return your completed survey in the included postage-paid envelope by **March 31, 2022**. Your responses are anonymous, and your information will only be used as authorized under British Columbia’s *Freedom of Information and Protection of Privacy Act*.
- If you have any questions or need help in completing this survey, you are welcome to call the Office of the Seniors Advocate at 1-877-952-3181, Monday to Friday, 8:30 am – 4:30 pm, except statutory holidays.
- Your feedback is very important for improving services for seniors in BC. Thank you!

*Your survey responses are collected by the Office of the Seniors Advocate, Ministry of Health, under Sections 26(a), 26(c), and 26(e) of the Freedom of Information and Protection of Privacy Act as well as under Section 7(a) of the Seniors Advocate Act, and they will be used for program planning and evaluation. If you have any questions about the collection of this personal information, please contact the Office of the Seniors Advocate, PO Box 9651, STN PROV GOVT Victoria BC, V8W 9P4, 1-877-952-3181.*

## Income and Affordability Survey for BC Seniors

**HOUSING:** We would like to know a little bit about your current living situation.

**1) Please describe your current residence.**

- |  |  |
|--|--|
| <input type="checkbox"/> Single detached house or duplex           | <input type="checkbox"/> Apartment/townhouse/condominium |
| <input type="checkbox"/> Manufactured home (including mobile home) | <input type="checkbox"/> Other                           |

**2) How long have you lived in your current residence?**

[\_\_\_\_\_] years

**3) Do you live alone?**

- |                              |  |
|------------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No; [_____] other people live with me |
|------------------------------|--|

**4) Do you currently rent or own your residence?**

- |                                 |                                |
|---------------------------------|--------------------------------|
| <input type="checkbox"/> I rent | <input type="checkbox"/> I own |
|---------------------------------|--------------------------------|

The next set of questions (Questions 5 to 7) apply to those who rent.  
If you own your home, please go to Question 8.

**5) What is your current monthly rent?**

\$ [\_\_\_\_\_]

**6) What does your monthly rent include? Please select all that apply.**

- |                                   |                                  |
|-----------------------------------|----------------------------------|
| <input type="checkbox"/> Heat     | <input type="checkbox"/> Water   |
| <input type="checkbox"/> Internet | <input type="checkbox"/> Parking |
| <input type="checkbox"/> Cable TV |                                  |

**7) Do you currently receive the BC Housing Shelter Aid for Elderly Renters (SAFER) subsidy?**

- |   |   |
|---|---|
| <input type="checkbox"/> Yes                  | <input type="checkbox"/> No, I do not know about it |
| <input type="checkbox"/> No, I do not qualify |   |

The next set of questions (Questions 8 to 13) apply to those who own their home.  
If you rent, please go to Question 14.

8) Do you have a mortgage?

Yes

No [Please go to Question 10]

9) What is your estimated monthly mortgage payment?

\$ [\_\_\_\_\_]

10) If applicable, please estimate how much you pay each month for a strata or condominium type fee?

\$ [\_\_\_\_\_]

11) Has your home ever needed major repairs that you could not afford? For example: a leaking roof, rotted deck or fence.

Yes

No

12) Have you accessed the BC Property Tax Deferment Program?

Yes

I choose not to use it

I do not know what this is

13) On average, how much do you pay for utilities in a month? Please include heat, hydro, gas, oil, and water/sewer.

Under \$50

\$50 - \$99

\$100 - \$299

\$300 or more

**HEALTH:** This section asks you to consider your healthcare expenses and the types of healthcare services you use.

**14) During the past 12 months, have you received any help or care from others? Please select all that apply.**

- |   |   |
|---|---|
| <input type="checkbox"/> Unpaid help from family or friends | <input type="checkbox"/> Home support from the Health Authority |
| <input type="checkbox"/> Private home support/nursing care  | <input type="checkbox"/> Private housekeeping                   |
| <input type="checkbox"/> Better at Home                     | <input type="checkbox"/> I do not need help or care             |
| <input type="checkbox"/> I need help but cannot afford it   |   |

**15) When was your last visit to the dentist?**

- |  |   |
|--|---|
| <input type="checkbox"/> Within the past 12 months | <input type="checkbox"/> 1 to 2 years ago |
| <input type="checkbox"/> 3 years ago, or more      | <input type="checkbox"/> Never            |

**16) Did you pay any amount for this dental visit?**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes, I paid the full cost                 | <input type="checkbox"/> Yes, I paid a partial cost                     |
| <input type="checkbox"/> No, it was fully covered by a health plan | <input type="checkbox"/> Not applicable, I have not been to the dentist |

**17) Have you ever needed dental care (including check ups, dental crown, bridges, fillings) that you could not afford?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**18) Do you wear dentures?**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                               | <input type="checkbox"/> No, I do not need them |
| <input type="checkbox"/> No, I need them but cannot afford |   |

**19) Have you ever visited a clinic offering low-cost dental services (e.g., clinics that provide dental services at reduced rates)?**

- |   |                             |
|---|-----------------------------|
| <input type="checkbox"/> Yes [Please go to Question 21] | <input type="checkbox"/> No |
|---|-----------------------------|

**20) If you have not visited a low-cost dental clinic, what are the reasons? Please select all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> I do not know about them    | <input type="checkbox"/> There are none in my community |
| <input type="checkbox"/> I cannot get an appointment | <input type="checkbox"/> I cannot get there             |
| <input type="checkbox"/> I am not comfortable going  | <input type="checkbox"/> I do not need them             |

**21) When was your last eye exam?**

- |  |   |
|--|---|
| <input type="checkbox"/> Within the past 12 months | <input type="checkbox"/> 1 to 2 years ago |
| <input type="checkbox"/> 3 years ago, or more      | <input type="checkbox"/> Never            |

**22) Did you pay any amount for this eye exam (full/partial cost)?**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes, I paid the full cost                 | <input type="checkbox"/> Yes, I paid a partial cost                 |
| <input type="checkbox"/> No, it was fully covered by a health plan | <input type="checkbox"/> Not applicable, I have not had an eye exam |

**23) Do you wear prescription eyeglasses?**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                               | <input type="checkbox"/> No, I do not need them |
| <input type="checkbox"/> No, I need them but cannot afford |   |

**24) If applicable, please indicate when you had your last hearing test?**

- |  |   |
|--|---|
| <input type="checkbox"/> Within the past 12 months | <input type="checkbox"/> 1 to 2 years ago |
| <input type="checkbox"/> 3 years ago, or more      | <input type="checkbox"/> Never            |

**25) Did you pay any amount for this hearing test (full/partial cost)?**

- |  |  |
|--|--|
| <input type="checkbox"/> Yes, I paid the full cost | <input type="checkbox"/> Yes, I paid a partial cost                        |
| <input type="checkbox"/> No, I was not charged     | <input type="checkbox"/> Not applicable, I have not had my hearing checked |

**26) Do you use a hearing aid(s)?**

- |  |   |
|--|---|
| <input type="checkbox"/> Yes                               | <input type="checkbox"/> No, I do not need it |
| <input type="checkbox"/> No, I need them but cannot afford |   |

**27) Please tell us about any mobility devices you use or need but cannot afford.**

	I use	I need but cannot afford	I do not need
Cane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Scooter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**28) On average, how much do you estimate that you pay for medications (including prescription and over the counter medications) in a month?**

- I do not need
  Under \$50  
 \$50 - \$99
  \$100 or more

**29) Have you been prescribed any medications that you have not been able to afford?**

- Yes
  No

**30) Are you covered by an extended health benefits plan?**

*(Health benefits may include coverage for some or all of the following: vision, dental, hearing, mobility aids, prescription drugs, medical supplies, and/or other services NOT COVERED by Fair PharmaCare.)*

- Yes
  No

**31) In the past 2 years, have you ever needed, but could not afford, any of the following?  
Please select all that apply.**

- Eyeglasses
  Dental care  
 Dentures
  Hearing test  
 Hearing aids
  Medication  
 Medical equipment (i.e., wheelchair or walker)
  Occupational therapy  
 Physiotherapy
  Counseling or mental health support  
 Foot care (podiatry)
  Chiropractor, acupuncture, or massage therapy

**FINANCIAL:** This section asks about your sources of income, financial stressors, and future financial planning.

**32) Which of the following best describes how well you are managing financially these days?**

- I manage to pay all my bills each month       I usually pay all my bills each month  
 I sometimes pay all my bills each month       I seldom pay all my bills each month  
 I never pay all my bills each month

**33) Please tell us how difficult you generally find it to cover the following expenses?**

	Very difficult	Difficult	Somewhat difficult	Not difficult	Not applicable
Housing (rent, mortgage)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Utilities (e.g., heat, water)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication/supplements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hiring people to help me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Replacing clothes, shoes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medical supplies such as incontinence supplies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**34) In the past 12 months, have you had to cut back spending on essentials to pay for another essential expense? For example, have you ever had to cut back on groceries to help pay for your rent?**

- All of the time       Most of the time  
 Some of the time       Never

**35) How confident are you that you could find \$1,000 or more to pay for an unexpected expense, such as a dental emergency, car repairs, or hot water tank replacement?**

- Very confident       Confident  
 Somewhat confident       Not confident





**SUPPORTS:** This section asks about support programs and your ability to apply for them.

**40) How well does each of the following programs meet your needs?**

	Very well	Somewhat well	Not too well	Not at all	Not applicable
Old Age Security (OAS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Guaranteed Income Supplement (GIS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC Seniors Supplement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shelter Aid for Elderly Residents (SAFER)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fair PharmaCare	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Property Tax Deferment Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HandyDART	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TaxiSaver vouchers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BC Bus Pass Program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**41) How do you complete your annual tax return?**

- |  |  |
|--|--|
| <input type="checkbox"/> I prepare my own taxes              | <input type="checkbox"/> Someone in my household prepares my taxes |
| <input type="checkbox"/> With help of a volunteer tax clinic | <input type="checkbox"/> With help from family or a friend         |
| <input type="checkbox"/> Paid accountant or tax preparer     | <input type="checkbox"/> Other                                     |

**42) How confident are you completing ONLINE forms or applications?**

- |   |  |
|---|--|
| <input type="checkbox"/> Very confident     | <input type="checkbox"/> Confident     |
| <input type="checkbox"/> Somewhat confident | <input type="checkbox"/> Not confident |

**43) How do you find out about support programs and services for seniors? Please select all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> Internet                          | <input type="checkbox"/> BC Seniors Guide   |
| <input type="checkbox"/> My local seniors/community centre | <input type="checkbox"/> Newspaper          |
| <input type="checkbox"/> Office of the Seniors Advocate    | <input type="checkbox"/> Friends and family |
| <input type="checkbox"/> Other                             |   |

**44) What is your preferred way to find information about seniors' programs and services?**

- I search online
- I phone
- I go in person

**COSTS OF LIVING:** This section asks what you typically spend on food, transportation, and technology.

**45) Does your household ever run out of money to buy food?**

- All the time
- Most of the time
- Some of the time
- None of the time

**46) Have you ever accessed a food bank?**

- Yes, regularly
- Yes, occasionally
- No, I could not get there
- No, I did not need it
- No, I do not know where it is

**47) On average, how much does your household spend on groceries in a week?**

- Under \$50
- \$50 - \$99
- \$100 - \$199
- \$200 or more

**48) On average, how much do you spend on transportation in a month, including car payments, insurance, gas, parking, bus fare or taxis?**

- Under \$50
- \$50 - \$99
- \$100 - \$199
- \$200 or more

**49) What transportation costs, if any, make it hard for you to get where you need to go?**

**Please select all that apply.**

- |  |   |
|--|---|
| <input type="checkbox"/> Cost of renewing my drivers license | <input type="checkbox"/> Buying and/or maintaining a reliable vehicle |
| <input type="checkbox"/> Gas                                 | <input type="checkbox"/> Car insurance                                |
| <input type="checkbox"/> Parking                             | <input type="checkbox"/> Bus fare/monthly bus pass                    |
| <input type="checkbox"/> Taxi                                | <input type="checkbox"/> None   |

**50) Can you access the internet in your home?**

- |   |                             |
|---|-----------------------------|
| <input type="checkbox"/> Yes [Please go to Question 52] | <input type="checkbox"/> No |
|---|-----------------------------|

**51) If applicable, please tell us how you regularly access the internet.**

- |  |   |
|--|---|
| <input type="checkbox"/> Library                   | <input type="checkbox"/> Seniors/Community Centre     |
| <input type="checkbox"/> Coffee shop or restaurant | <input type="checkbox"/> Family or friend             |
| <input type="checkbox"/> Other                     | <input type="checkbox"/> I do not access the internet |

**52) Do you have any of the following devices? Please select all that apply.**

- |   |  |
|---|--|
| <input type="checkbox"/> Cell phone or smartphone       | <input type="checkbox"/> Tablet (e.g., iPad)               |
| <input type="checkbox"/> Computer or laptop             | <input type="checkbox"/> No, I choose not to use them      |
| <input type="checkbox"/> No, I cannot afford to buy one | <input type="checkbox"/> No, I do not know how to use them |

**53) Do you have an email address that you check on a regular basis?**

- |                              |                             |
|------------------------------|-----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No |
|------------------------------|-----------------------------|

**DEMOGRAPHICS:** This section asks you to tell us a bit about yourself.

**54) What is your age?**

- |  |                                      |
|--|--------------------------------------|
| <input type="checkbox"/> 65 - 69           | <input type="checkbox"/> 70 - 74     |
| <input type="checkbox"/> 75 - 79           | <input type="checkbox"/> 80 - 84     |
| <input type="checkbox"/> 85 - 89           | <input type="checkbox"/> 90 or older |
| <input type="checkbox"/> Prefer not to say |                                      |

**55) What is your gender?**

- |                                |  |
|--------------------------------|--|
| <input type="checkbox"/> Male  | <input type="checkbox"/> Female            |
| <input type="checkbox"/> Other | <input type="checkbox"/> Prefer not to say |

**56) What is your current marital status?**

- |  |  |
|--|--|
| <input type="checkbox"/> Single                | <input type="checkbox"/> Married or common-law partner |
| <input type="checkbox"/> Divorced or separated | <input type="checkbox"/> Widowed                       |
| <input type="checkbox"/> Other                 | <input type="checkbox"/> Prefer not to say             |

**57) Do you consider English to be your first language?**

- |  |                             |
|--|-----------------------------|
| <input type="checkbox"/> Yes               | <input type="checkbox"/> No |
| <input type="checkbox"/> Prefer not to say |                             |

**58) Please tell us the first three-digits of your postal code.**

- [\_\_ \_\_ \_\_] [ e.g., V9A]  Prefer not to say

**59) Do you consider yourself to be: Please select all that apply.**

- First Nations
- Inuit
- Chinese
- Black (e.g., African, Caribbean)
- South Asian (e.g., East Indian, Pakistani, Sri Lankan)
- Arab
- Korean
- Other
- Metis
- White (European descent)
- Filipino
- Latin American/Hispanic
- Southeast Asian (e.g., Vietnamese, Cambodian, Malaysian, Laotian)
- West Asian (e.g., Iranian, Afghan)
- Japanese
- Prefer not to answer

**60) When thinking about the services and supports you need but are not receiving, please tell us what would have the biggest impact on improving your quality of life.**

**61) Please let us know if you have any additional comments.**

Thank you very much for sharing your feedback with us. Please be assured that your responses are confidentially collected by the Office of the Seniors Advocate, Ministry of Health, under Sections 26(a), 26(c), and 26(e) of the *Freedom of Information and Protection of Privacy Act* as well as under Section 7(a) of the *Seniors Advocate Act*, and they will be used for program planning and evaluation. Your answers cannot be used to identify you.

We can also answer any questions you may have about this survey. Our contact information is on the cover letter of this survey. Once again, thank you for taking the time to share your experience with us.