

New York State Coalition for the Aging, Inc.

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MEMBERSHIP SURVEY

Although NYSCA does not currently offer all of the services listed below, we are reviewing these as potential member services and would like to have your input on increasing the services we provide to our members. Please take a moment and fill out this membership survey. This information will make it easier for us to determine the needs our members and to help us represent you more effectively. Please return this survey to us as soon as possible – THANK YOU

Organization Name _____ Phone # (____) _____

Address: _____ City _____ State _____ Zip _____

Contact Person _____ # Seniors You Represent _____ Fax # (____) _____

Email: _____ Website: _____

County (ies) Served _____

Would you consider being part of a speaker's bureau? Yes / No

Specialties: _____

Would you take part in a regional meetings on advocacy and local community needs? Yes / No

Would you like your organization listed on the NYSCA website with a link to your website? Yes / No

Are you currently participating in any group purchasing program? Yes / No

If yes, please specify name and items purchased: _____

Programs and services of interest to your organization (check all that apply please)

Group Purchasing Programs:

Insurance Programs _____

Health/Dental Insurance _____

Office Supplies _____

Payroll Services _____

Unemployment Savings _____

Disability Insurance _____

Worker's Compensation _____

Other (Please specify) _____

Technical Assistance:

General Organizational Assistance _____

Board/Staff relations _____

Fund Development _____

Strategic Planning _____

General legal assistance _____

Other (Please specify) _____

OVER

Management & Leadership Training:

Advocacy training _____
Board Training/Development _____
Fundraising _____
Grant writing _____
New Director training _____
NISC certification training _____

Other (Please specify): _____

Program Training/Workshops:

Mental Health Issues _____
Caregiver Support _____
Stress Management _____
Crisis Intervention _____
Program Development _____
Long Term Care Reform _____
Volunteer Recruitment/evaluation _____

Other (Please specify): _____

Funding – (please list the approximate proportion of your funding under each line)

Federal _____% State _____% Local _____% Participant Contributions _____% Donations _____%
Private Foundations _____% United Way _____%

Service Funding – If you had a choice, which services would you like to see additional resources put into:

EISEP _____
CSI _____
NORC _____
SNAP _____
Social Adult Day _____
Transportation _____
Others (Please Specify) _____

Do you have an advisory council made up of senior citizens? Yes / No

Are they active? Yes / No How often do they meet _____

Would you be interested in an advocacy training with you advisory council? Yes / No

If yes, who should we contact regarding this training _____

Phone number (____) _____ Email: _____

Capital Needs - Do you have any capital needs (repair or replace equipment, vans, transportation funds, kitchen equipment, meal preparation equipment, construction needs, and so forth)? Please list _____

Other – Are there any other issues, trends, barriers to providing services to seniors that are not listed above that you are dealing with? Please describe: _____

Thank you for taking the time to complete and return this valuable survey!

Return to:
Joanne Macklin
Executive Director
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