Annual Para Athlete Accessibility Survey

Para Athletes,

To further USA Archery's (USAA) commitment to Paralympic parity, USAA has created this survey-based assessment, to address and support Paralympic athletes' needs for accessibility accommodation at USAA programs, camps and events.

Please be aware that most of the information requested is private health information and is protected under the Health Insurance Portability and Accountability Act (HIPAA), therefore, all information provided is optional and voluntary.

All information will be collected and stored in a secure location on HIPAA-compliant cloud storage with encryption and consistent with USAA's record retention policy. Any specific data and/or identifying information is restricted to necessary staff only. The USA Archery Board of Directors and select USA Archery Staff will have access to summarized data with no identifying information for the purpose of discussing improvements that can be made for athletes' needs and accessibility accommodations. The data collected will be incorporated into event planning, staff selection, and logistics planning and travel to camps and events, as applicable.

Please be advised that the information provided on the survey does not and will not impact team selection and is not related to Personal Care Assistant (PCA) selection. The intent of this data collection is to understand individual athlete needs. USAA Staff will do their best to accommodate all needs based on final credential allocation, overall team size, event location, and accommodation availability. Please be advised that for international events, USAA will do their best to coordinate with the local organizers to ensure accommodations are available, but requested accommodations may not be available in some instances.

Survey Monkey is a HIPAA-compliant survey tool.

There are various options for completing:

1. Self-Complete
2. You may opt to select a proxy to complete this survey on your behalf, such as a caretake, medical professional, and/or healthcare provider. If you use a proxy, please include their information.
3. You may opt to attach supplemental documentation, such as case notes and/or assessments from a medical professional and/or healthcare provider. Please note that if you select this option, USAA may have some follow up questions to confirm needs and accessibility if information does not match exactly. USAA will not assume, nor interpret needs or accessibility.

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4. You may opt not to complete the survey at all. All information provided is provided voluntarily.

Please be advised that this survey will be effective as of August 1, 2023. If you need to make changes after you have submitted this survey, please email **ndeines@usarchery.org** and request access.

If you have already completed a survey and only wish to update your information, please select the box "Updating Information Only". The fields with new data will be merged with your existing survey entries.

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Introduction

Please take the time to complete this survey thoroughly and honestly. Our goal is to better understand and serve your accessibility needs on and off the field of play. If you'd prefer to answer the questions over the phone or elaborate on specific needs, please contact me directly at ndeines@usarchery.org.

As you move through the survey, each section will conclude with a Comment Box for you to include additional information. Answers should reflect must-haves versus nice-to-haves.

We understand the sensitivity around this information. Please note your responses will only be visible to the following team members:

- USOPC Sports Medicine Staff
- USA Archery Medical Staff/Contractors
- USA Archery Staff, as needed

Completing this survey will not have an impact on future team selection.

The Office of the Athlete Ombuds offers independent, confidential advice to elite athletes regarding their rights and responsibilities in the Olympic and Paralympic Movement, and assists athletes with a broad range of questions, disputes, complaints and concerns. Reach out with questions or for support at ombudsman@usathlete.org or (719)866-5000.

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Demographic

1. Please select this box if you have previously completed this survey and are updating information only. If not applicable, leave blank and proceed to next section.

- [ ] I am updating my previously submitted survey responses

ATHLETE CONTACT INFORMATION

2. First Name

3. Last Name

4. Date of Birth (MM/DD/YYYY)

5. Cell Phone Number (Preferred Phone Number to be used Prior to and During Events)

6. Email Address

7. Sex at Birth

8. Emergency Contact- First Name

9. Emergency Contact- Last Name

10. Emergency Contact- Date of Birth (MM/DD/YYYY)

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Demographic (Cont'd)

11. Pronouns

12. Preferred Method of Communication

13. Parent/Guardian Name- Minor Athlete Only

14. Is a proxy completing this survey on your behalf?

- ◯ Yes
- ◯ No

15. Proxy Name

16. Proxy Role and/or Relation

Other (please specify)

17. Proxy Cell Phone Number

18. Proxy Email Address

19. Preferred Departing/Returning Airport (Please be as specific as possible)

20. Preferred Seating Option

- ◯ Window
- ◯ Middle
- ◯ Aisle
- ◯ No Preference

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Impairment

21. Para Classification Type

- ◯ W1 (Most Severely Impaired Group)
- ◯ W2 (Wheelchair)
- ◯ ST (Standing)
- ◯ NE (Non-Eligible)
- ◯ VI 1 (Visually Impaired)
- ◯ VI 2/3 Combined (Visually Impaired)
- ◯ Other Non-Classified Impairments (Please Specify: Physical, Cognitive, Deaf/Hard of Hearing, Intellectual, PTSD, etc...)

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Mobility Support and Assistive Devices

22. Do you use any mobility support and/or assistive devices? (Check all that apply)

- [ ] Scooter
- [ ] Crutches
- [ ] Cane
- [ ] Brace
- [ ] Prosthesis
- [ ] Walker
- [ ] Stool
- [ ] Wheelchair
- [ ] Hearing Aids
- [ ] Cochlear Implants
- [ ] Braille
- [ ] Screen Magnifier
- [ ] Screen Reader
- [ ] Other (please specify)

- [ ] None of the above

23. Please share more about the mobility support and/or assistive device utilized, to include use, frequency, dependency, limitations and/or any other relevant information you feel is pertinent for us to be aware of.

24. If you selected 'yes' to any of the above, does the mobility support and/or assistive device fold?

- ◯ Yes
- ◯ No

25. If you selected 'yes', identify the mobility support and/or assistive device that folds.

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Mobility Support and Assistive Devices: Wheelchair

Answer the following questions if you selected 'yes' and use a wheelchair.

26. What type of wheelchair do you use?

- ◯ Power, Wet
- ◯ Power, Dry
- ◯ Manual

27. How wide is your wheelchair?

28. How long is your wheelchair?

29. How tall is your wheelchair?

30. What is the weight of the wheelchair itself?

31. What is the weight of the wheelchair AND you in the wheelchair?

32. Do you use a Firefly?

- ◯ Yes
- ◯ No

33. If so, what is the weight of the Firefly?

34. If so, what are the dimensions of the Firefly?

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Mobility Support and Assistive Devices: Hearing

Answer the following questions if you selected 'yes' and use hearing assistive devices.

35. What is your degree of deaf or hard of hearing?

- ◯ Totally deaf
- ◯ Somewhat deaf
- ◯ Hard of hearing
- ◯ Other (please specify)

36. Do you require hearing assistive devices?

- ◯ Yes, cochlear implants
- ◯ Yes, hearing aids

37. Do you read lips?

- ◯ Yes
- ◯ No

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Mobility Support and Assistive Devices: Visual

Answer the following questions if you selected 'yes' and use visual assistive devices.

38. What is your degree of visual difficulty?

- ◯ Totally blind
- ◯ Blind- can see light and shapes
- ◯ Low visioned- limited visual acuity
- ◯ Low visioned- high visual acuity
- ◯ Bad vision- not legally blind
- ◯ Other (please specify)

39. Do you use any of the following assistive devices? (Check all that apply)

- ☐ Screen reader
- ☐ Closed captions
- ☐ Messaging platforms

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Allergies

40. Do you have any food allergies? (Check all that apply)

- [ ] Gluten
- [ ] Dairy
- [ ] Peanut Butter
- [ ] Tree Nuts
- [ ] Shellfish
- [ ] Other (please specify)

41. If you answered 'yes' to any food allergies, what is the reaction(s)? (Check all that apply)

- [ ] Anaphylaxis
- [ ] GI Distress
- [ ] Hives and/or Itching
- [ ] Rash
- [ ] Swelling
- [ ] Sneezing
- [ ] Running Nose
- [ ] Shortness of Breath
- [ ] Trouble Breathing
- [ ] Headache
- [ ] Other (please specify)

42. Do you have any dietary restrictions? If yes, please list.

43. Do you have non-food related allergies? (i.e. medication, fragrance, materials, bees, sunblock, etc.) If yes, please list known allergies.

44. If you answered 'yes' to any non food related allergies, what is the reaction? (Check all that apply)

- [ ] Anaphylaxis
- [ ] GI Distress
- [ ] Hives and/or Itching
- [ ] Rash
- [ ] Swelling
- [ ] Sneezing
- [ ] Running Nose
- [ ] Shortness of Breath
- [ ] Trouble Breathing
- [ ] Headache
- [ ] Other (please specify)

45. Do you have difficulty regulating your temperature (i.e. overheating, etc.)?

- ◯ Yes
- ◯ No

46. If 'yes', what helps you regulate your temperature? And what assistance do you require from staff?

47. If you selected 'yes' to any of the above, please use the comment box to provide additional information and your specific needs.

48. How much time do you need to transfer between planes and airport terminals?

49. Do you use any of the following? (Check all that apply)

- [ ] Service animal
- [ ] Support with wayfinding (propiospatial orientation) or navigation
- [ ] Special accommodations for ground transportation
- [ ] Special accommodations for lodging
- [ ] Assistance carrying or transporting luggage

50. If so, please share more about the accommodations and supported needed.

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Critical Activities of Daily Living

For this section, we are trying to better understand your needs OFF the field. We've identified five categories covered under "critical activities of daily living".

Definitions:

- **Personal hygiene- bathing/showering, grooming, nail care, and oral care**
- **Restroom use- the ability to physically use a restroom, this includes the ability to get on and off the toilet, and cleaning oneself**
- **Eating- the ability to feed oneself, though not necessarily the ability to prepare food**
- **Transferring/ Mobility- being able to stand from a sitting position, as well as get in and out of bed; the ability to independently get from one location to another**

51. Personal Hygiene: Please rate your level of support needs in the following situations.

	"Assistance is essential, I cannot complete without assistance"	"I can complete the task if I have assistive devices"	"Assistance is helpful, not required. Would save many attempts, could complete eventually."	"Not applicable"
Do you need support with bathing and/or showering?	○	○	○	○
Do you require a shower stool, grab bar, roll in shower chair or other assistive device?	○	○	○	○
Do you require a roll in shower?	○	○	○	○
Do you need support with brushing your teeth?	○	○	○	○
Do you need support to take daily medication? (Injection, opening and closing containers, reminders to take medication)	○	○	○	○

Please add any comments:

52. Restroom Use: Please rate your level of support needs in the following situations.

	"Assistance is essential, I cannot complete without assistance"	"I can complete the task if I have assistive devices"	"Assistance is helpful, not required. Would save many attempts, could complete eventually."	"Not applicable"
Are you able and comfortable transferring out of your chair by yourself to use restroom with or without grab bars?	○	○	○	○
Do you need support to use the restroom?	○	○	○	○
Do you have a bowel routine?	○	○	○	○
Do you use a transfer board?	○	○	○	○

Please add any comments:

53. Do you require assistance with a catheter?

- ○ Yes
- ○ No

54. Do you have autonomic dysreflexia (abnormal, overreaction of the involuntary (autonomic) nervous system to stimulation)?

55. If you selected 'yes', which of these do you experience? (Check all that apply)

- ☐ Change in heart rate
- ☐ Excessive sweating
- ☐ High blood pressure
- ☐ Muscle spasms
- ☐ Skin color changes (paleness, redness, blue-gray colored skin)
- ☐ Other (please specify)

56. Do you have difficulty regulating your bladder?

57. If you must hold your bladder, are there any negative side effects or consequences?

58. Do you need assistance getting dressed?

- ◯ The entire process
- ◯ Some parts of the process (i.e. buttons, zippers)
- ◯ Some parts of the process as needed
- ◯ Not at all

59. Eating: Please rate your level of support needs in the following situations.

	"Assistance is essential, I cannot complete without assistance"	"I can complete the task if I have assistive devices"	"Assistance is helpful, not required. Would save many attempts, could complete eventually."	"Not applicable"
Do you need support serving yourself food from a buffet line?	◯	◯	◯	◯
Do you need support to prepare your food? (i.e. making toast, using waffle machine)	◯	◯	◯	◯
Do you need support accessing food? (i.e. opening containers, putting a straw in a juice box)	◯	◯	◯	◯
Do you require assistance carrying a food tray?	◯	◯	◯	◯
Do you need support to order food?	◯	◯	◯	◯
Do you need support to cut your food?	◯	◯	◯	◯
Do you need support to feed yourself?	◯	◯	◯	◯
Do you require assistance returning items or throwing away items? (i.e. throwing trash away, returning a tray)	◯	◯	◯	◯

Please add any comments:

60. Do you have difficulty swallowing?

- ◯ Yes
- ◯ No

61. Are you prone to choking?

- ◯ Yes
- ◯ No

62. Do you require someone to monitor you while eating in case of choking?

- ◯ Yes
- ◯ No

63. Transferring/Mobility: Please rate your level of support needs in the following situations.

	"Assistance is essential, I cannot complete without assistance"	"I can complete the task if I have assistive devices"	"Assistance is helpful, not required. Would save many attempts, could complete eventually."	"Not applicable"
Do you need support transferring out of your chair to get into bed?	○	○	○	○
Do you need a Hoyer lift or a transfer board to transfer in and out of bed?	○	○	○	○
Do you need support transferring out of your chair to get into a sedan?	○	○	○	○
Do you need support to climb stairs?	○	○	○	○
Do you need support to sidestep down aisles or tight spaces?	○	○	○	○
Do you need support to ride on able body busses?	○	○	○	○
Do you need support to walk?	○	○	○	○
Do you need an agent at the airport to check in?	○	○	○	○
Do you need an agent at the airport to transfer between terminals?	○	○	○	○

Please add any comments:

64. If you need support to climb stairs, how many stairs are you able to climb at a time?

65. Are you able to carry anything while climbing stairs?

- ○ Yes
- ○ No

66. Do you require a handrail when climbing stairs?

- ◯ Yes
- ◯ No

67. If you need support to descend stairs, how many stairs are you able to descend at a time?

68. Are you able to carry anything while descending stairs?

- ◯ Yes
- ◯ No

69. If you need support to walk, how far are you able to walk without support?

70. Are there limits to distances you can walk or traverse in a wheelchair? If so, what are those limits and/or distances?

71. Are there limits to types of terrain that can be walked or traversed in a wheelchair? If so, what are those limits?

72. Do you require support in certain conditions only? If so, what are those conditions?

73. Please use the comment box to provide any additional information related to critical activities of daily living needs.

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Personalized Medical Care

We would like to gain a better understanding of the personalized medical care you receive, if any. If you would prefer to discuss your care over the phone and/or to provide more detail than what the survey asks, please contact ndeines@usarchery.org.

74. What types of personalized medical care do you receive? (Include frequency, i.e. daily/ weekly)

75. Who do you typically receive medical care from?

76. What is your expectation for how medical care be provided at USA Archery programs, camps, and events?

77. Please use this comment box to provide any additional information.

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PCA Preferences

The data collected from this assessment survey will be incorporated into competition planning and medical staff selection for events. However, accreditation allocation is not guaranteed and will be based on final credential allocation and overall team size.

78. Do you receive support from a Personal Care Assistant (PCA)?

- ◯ Yes
- ◯ No

79. Who are you most comfortable receiving support from and what is their relation to you?

80. Including a why, please describe the support that this person provides currently in your daily life.

81. Is your current PCA willing and able to assist other athletes if needed and if staff credentials are limited?

- ◯ Yes
- ◯ No

82. Are you willing to utilize a PCA assigned by USA Archery to assist multiple athletes?

- ◯ Yes
- ◯ No

83. Please use the comment box to provide any additional information.

If something changes between the time you completed this survey and the time of the event, please remember to update your survey and resubmit.