

### Unsheltered Count Form for Night of Count

Location: _____	Town: _____	Zip Code: _____	County: _____
Interviewer: _____	Date: _____	Time: _____	AM/PM

Hello, my name is \_\_\_\_\_ and I'm a volunteer for the *[NAME OF CoC]*. We are conducting a survey to count homeless people to provide better programs and services to them. Your participation is voluntary. The information collected will be entered into the Homeless Management Information System (HMIS) and may be used in a non-identifying manner for statewide statistics and research. Can I have about 10 minutes of your time?

Yes → **[GO TO Q1]**     No → **[THANK RESPONDENT]**

<p><b>1. Where are you sleeping tonight?</b></p> <p><b>[DO NOT READ CATEGORIES. SELECT ONLY ONE CATEGORY]</b></p>	<p>1. Street or sidewalk</p> <p>2. Vehicle (car, van, RV, truck)</p> <p>3. Park</p> <p>4. Abandoned Building</p> <p>5. Bus, train station, airport</p> <p>6. Under bridge/overpass</p> <p>7. Woods or outdoor encampment</p> <p>8. Other location</p>	<p>9. Emergency Shelter (including Hotel/Motel paid for with Shelter voucher)</p> <p>10. Transitional Housing for homeless persons</p> <p>11. Safe Haven</p>	<p><b>[GO TO Q2]</b></p>	<p><b>[SAY: YOU WILL BE INCLUDED IN THE COUNT AT THESE LOCATIONS, THANK YOU FOR YOUR TIME.]</b></p>
<p><b>2. Did another volunteer or survey worker already ask you these same questions about where you are staying tonight?</b></p>	<p><input type="checkbox"/> YES → Thank them for taking the survey</p> <p><input type="checkbox"/> NO</p> <p><input type="checkbox"/> DK/REF</p>			
<p><b>3. Including yourself, how many adults, and children are there in your household, <u>who are sleeping in the same location with you tonight?</u></b></p>	<p>_____ Adults ( Age 18 and older)</p> <p>_____ Children (Age 17 and younger)</p>			
<p><b>4a. What is your full name? (PERSON 1)</b> [IF RESPONDENT SAYS "DON'T KNOW OR "REFUSED", WRITE DK/REF]</p>	<p><b>Person 1</b></p>			

	<b>Person 2</b>	<b>Person 3</b>	<b>Person 4</b>	<b>Person 5</b>
<p><b>4b. What are the full names of the other people in your household?</b> [IF DON'T KNOW OR REFUSED, WRITE DK/REF]</p>				

[COMPLETE THE COLUMN FOR PERSON 1 BY ASKING Q7-Q18. THEN COMPLETE THE COLUMNS FOR PERSONS 2-5 FOR ALL OTHER HOUSEHOLD MEMBERS BY ASKING Q5-Q18 FOR EACH PERSON. IF OTHER HOUSEHOLD MEMBERS ARE PRESENT, ASK EACH INDIVIDUALLY FOR THEIR ANSWERS TO Q5-18. IF OTHER HOUSEHOLD MEMEBERS ARE NOT PRESENT, PERSON 1 SHOULD ANSWER FOR THEM.] →

	Person 1	Person 2	Person 3	Person 4	Person 5
5. How is [each household member] related to you/person 1?	SELF	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non- Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non- Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non- Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non- Family
6. Just to confirm, are you staying with [person 1] here, in this location tonight? [IF NO, ASK Q6A, OTHERWISE, GO TO Q7]	[SKIP FOR PERSON 1]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
a. Where are you staying tonight? [RECORD NUMBER FROM Q1 CHOICES]	[SKIP FOR PERSON 1]	_____	_____	_____	_____
7. Did you stay in this same location last night? [IF NO, ASK Q7A]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
7a. Where did you stay last night?	_____ _____	_____ _____	_____ _____	_____ _____	_____ _____
8. How long did you stay/have you stayed in that location?	<input type="checkbox"/> 1 Week or Less <input type="checkbox"/> More than 1 Week but Less than 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> More than 3 Months but less than 1 Year <input type="checkbox"/> 1 Year or Longer <input type="checkbox"/> DK/Refused	<input type="checkbox"/> 1 Week or Less <input type="checkbox"/> More than 1 Week but Less than 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> More than 3 Months but less than 1 Year <input type="checkbox"/> 1 Year or Longer <input type="checkbox"/> DK/Refused	<input type="checkbox"/> 1 Week or Less <input type="checkbox"/> More than 1 Week but Less than 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> More than 3 Months but less than 1 Year <input type="checkbox"/> 1 Year or Longer <input type="checkbox"/> DK/Refused	<input type="checkbox"/> 1 Week or Less <input type="checkbox"/> More than 1 Week but Less than 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> More than 3 Months but less than 1 Year <input type="checkbox"/> 1 Year or Longer <input type="checkbox"/> DK/Refused	<input type="checkbox"/> 1 Week or Less <input type="checkbox"/> More than 1 Week but Less than 1 Month <input type="checkbox"/> 1-3 Months <input type="checkbox"/> More than 3 Months but less than 1 Year <input type="checkbox"/> 1 Year or Longer <input type="checkbox"/> DK/Refused
9. What is your date of birth? [IF HESITANT, ASK FOR YEAR]	_____	_____	_____	_____	_____

	Person 1	Person 2	Person 3	Person 4	Person 5
<b>10. Are you male, female, or transgender?</b>	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF
<b>11. Are you Hispanic or Latino?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>12. What is your race? You can select one or more races.</b>  <b>[READ CATEGORIES, DO NOT READ "Please Specify"]</b>	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ _____ <input type="checkbox"/> DK/REF
<b>13. What is the zip code of your last permanent address?</b> <b>[WHERE THE CLIENT LAST LIVED FOR 90 DAYS OR MORE]</b>	_____	_____	_____	_____	_____
<b>14. Are you employed?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>15. What is your highest level of education?</b> <b>[RECORD LAST GRADE/LEVEL COMPLETED]</b>	_____	_____	_____	_____	_____
<b>16. Is this the first time you have been homeless?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>17. How long have you been homeless <u>this time</u>? Only include the time spent staying in shelters and/or on the streets.</b> <b>[IF FIRST TIME HOMELESS – GO TO Q19]</b>	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF

	Person 1	Person 2	Person 3	Person 4	Person 5
18. Including this time, how many separate times have you stayed in shelters or on the streets in the <u>past 3 years</u> , (since January 2011)?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF
a. In total, how long did you stay in shelters or on the streets for those times? [ENTER DAYS OR WEEKS OR MONTHS OR YEARS]	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF	_____ Days _____ Weeks _____ Months _____ Years _____ DK/REF

Please tell me whether any of these situations apply to you.

19. Do you/Does Person [2-5] have...	Person 1	Person 2	Person 3	Person 4	Person 5
a. Any ongoing health problems or medical conditions such as diabetes, cancer, heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
b. Post-traumatic stress disorder or PTSD? [IF NECESSARY: a condition that can occur in people who have seen or had life threatening events such as natural disasters, serious accidents, war, or personal violence. It may cause feelings of detachment.]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
c. Psychiatric or emotional conditions such as depression or schizophrenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
d. Physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
e. AIDS or HIV-related illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

Have you/Has Person [2-5] ever...	Person 1	Person 2	Person 3	Person 4	Person 5
f. Received special education (or special ed) services for more than 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
g. Had a traumatic injury to your/their brain from a bump, blow, or wound to the head?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

	Person 1	Person 2	Person 3	Person 4	Person 5
<b>Just a few more questions:</b> <b>h. Do you/does person [2-5] have a substance abuse problem? [IF YES, INDICATE TYPE] [IF YES, ASK Q19-i]</b>	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF
<b>i. Have you, (has Person [2-5]) ever been treated for this substance abuse problem?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>[IF ONE OR MORE ANSWERS FROM A – I = YES, ASK J. IF PERSON HAS NONE OF THESE HEALTH ISSUES, SKIP TO Q20.]</b> <b>j. Do any of the situations we just discussed keep you from holding a job or living in stable housing?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>20. Have you ever been physically, emotionally, or sexually abused by a relative or another person you have stayed with, such as a spouse, partner, brother or sister, or parent?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

**\*\* [ONLY ASK QUESTIONS 21 – 24 TO PERSONS 18 AND OLDER] \*\***

	Person 1	Person 2	Person 3	Person 4	Person 5
<b>21. Do you/Does person [2-5] receive any disability benefits such as Social Security Disability Income, or Veteran's Disability Benefits</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>22. Have you served in the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>[IF Q 22 = NO, ASK Q23, OTHERWISE GO TO Q24]</b> <b>23. Were you ever called into active duty as a member of the National Guard or as a Reservist?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
<b>24. Have you ever received health care or benefits from the Veteran's Administration medical center?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

**Thank you for taking the survey!**