

2015 ME PIT Collection Form – Non-HMIS Participating Shelters, Transitional Housing, and Safe Havens

PLEASE COMPLETE ONE SHEET FOR EACH PERSON SERVED, WHETHER THEY ARE AN INDIVIDUAL OR A FAMILY MEMBER

Agency: _____ Town: _____ Zip Code: _____

County: _____ Interviewer: _____

Date: _____ Time: _____ AM/PM

“We are conducting a survey to count persons experiencing homelessness to provide better programs and services to them. Your participation is voluntary. The information collected will be used in a non-identifying manner for statewide statistics and research. Can I have about 10 minutes of your time?”

Where are you sleeping tonight?
[SELECT ONLY ONE CATEGORY]

- Emergency Shelter _____ Name of Shelter _____
- Transitional Housing for homeless persons _____ Name of Transitional Housing _____
- Safe Haven _____ Name of Safe Haven _____
- Hotel or Motel Paid for By _____ Name of Agency/Organization _____

If part of a Household, Name of Head of Household _____

Relationship to Head of Household _____

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

- Name Type:
- Full Name Reported
 - Partial, Street Name, or Code Name Reported
 - Client Doesn't Know
 - Client Refused
 - Data Not Collected

- DOB(mm/dd/yyyy) ____/____/____ DOB Type:
- Full DOB
 - Approximate or Partial DOB
 - Client Doesn't Know
 - Client Refused
 - Data Not Collected

- Primary Race:
- American Indian or Alaska Native
 - Asian
 - Black/African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Client Doesn't know
 - Client Refused
 - Data Not Collected

- Secondary Race:
- American Indian or Alaska Native
 - Asian
 - Black/African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Client Doesn't know
 - Client Refused
 - Data Not Collected

- Ethnicity:
- Hispanic/Latino
 - Non-Hispanic /Latino)
 - Client Doesn't Know
 - Client Refused
 - Data Not Collected

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Gender: Female Male Transgender Male to Female Transgender Female to Male Other - If other gender, specify _____ Client Doesn't Know Client Refused Data Not Collected

U.S. Military Veteran? (clients 18 and older): Yes No Client Doesn't Know Client Refused Data Not Collected

Residence Prior to Project Entry:

Table with 2 columns and 14 rows listing various housing types such as Emergency Shelter, Foster Care Home, Hospital, etc., with checkboxes for each.

Length of stay at location selected above: 1 day or less 2 days to 1 week More than 1 week but less than 1 month 1 to 3 months More than 3 months but less than 1 year 1 year or longer Client Doesn't Know Client Refused Data Not Collected

Have you been continuously Homeless for at Least One Year? Yes No Client Doesn't Know Client Refused

How many times have you been Homeless in the Past Three Years? 0 1 2 3 4 or more Client Doesn't Know Client Refused Data Not Collected

[IF ANSWER ABOVE IS 4 OR MORE, ASK]:

How many months (total) have you been Homeless in the Past Three Years? _____ (record number up to 12 months) More than 12 months Client Doesn't Know Client Refused Data Not Collected

How many months have you been continuously Homeless this time? _____

Zip code of last permanent address [WHERE THE CLIENT LAST LIVED FOR 90 DAYS OR MORE]: _____

Zip Code data quality: Full or Partial Client Doesn't Know Client Refused Data Not Collected

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****[INFORM RESPONDANT THAT THEIR RESPONSES TO DISABILITY RELATED QUESTIONS ARE VOLUNTARY AND THAT THEIR REFUSAL TO RESPOND WILL NOT RESULT IN A DENIAL OF SERVICE]**

Do you have a disability of long duration? Yes No Client Doesn't Know Client Refused Data Not Collected

[IF YES, RECORD TYPE AND ANSWER ADDITIONAL QUESTIONS]:

Disability Type	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	Documentation of the disability and severity on file?	Currently Receiving Treatment or Services?
Physical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been a victim of domestic violence? Yes No Client Doesn't Know Client Refused Data Not Collected

If yes, how long ago? Within the past three months More than a year ago
 Three to six months ago Client Doesn't know
 From six to twelve months ago Client Refused