



SHELTERED COUNT FORM

Use on: January 23, 2018

Use for: Sheltered Count interview (non-HMIS participating providers)

Sheltered Count Form- Ohio BoSCoC 2018 Point-in-Time Count

Shelter Information:

Location: _____ County: _____

Interviewer: _____ Date: _____ Time: _____ am/pm

Type of program (circle one): Emergency Shelter Transitional Housing

Hello, my name is _____ and I'm a volunteer for [Ohio BoSCoC County]. We are conducting a survey to count homeless people to provide better programs and services to them. Your participation is voluntary and your responses to questions will not be shared with anyone not associated with our survey. I need to read each question all the way through. Can I have about 10 minutes of your time?

Yes → [Go to Q1] No → [Thank respondent and go to Observation Tool]

1. Did another survey worker already ask you these same questions about where you are staying tonight?	<input type="checkbox"/> Yes → [Thank respondent for their time, end the survey] <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Refused				
2. Including yourself, how many adults and children are there in your household, who are sleeping in the same location with you tonight?	_____ Age 25 and older _____ Age 18-24 _____ Age 17 and younger				
3a. What are your initials? (Person 1) <i>[If respondent says Don't Know or Refused write DK or REF]</i>	Person 1	Person 2	Person 3	Person 4	Person 5
3b. What are the initials of other people in your household from oldest to youngest? <i>[If respondent says Don't Know or Refused write DK or REF]</i>					

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Person #1 Initials: _____

[Complete the column for Person 1 by asking Q4-Q17. Then complete the columns for Persons 2-5 for all other household members in order of oldest to youngest, by asking Q4-Q17 for each person individually (some questions may pertain only to persons age 18 and older). If other household members are not present, Person 1 should answer for them.]

	Person 1	Person 2	Person 3	Person 4	Person 5
4. How is Person ____ (Person 2-5) related to you (Person 1)?	<i>Self</i>	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other Relation Member <input type="checkbox"/> Other, Non-Relation Member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other Relation Member <input type="checkbox"/> Other, Non-Relation Member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other Relation Member <input type="checkbox"/> Other, Non-Relation Member	<input type="checkbox"/> Child <input type="checkbox"/> Spouse or Partner <input type="checkbox"/> Other Relation Member <input type="checkbox"/> Other, Non-Relation Member
5. Just to confirm, are you staying with ____ (Person 1) here, in this location, tonight?	<i>N/A</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 5a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 5a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 5a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 5a]</i> <input type="checkbox"/> DK/REF
<i>[If Q5=No, ask Q5a, otherwise go to Q6]</i> 5a. Where are you staying tonight? [If response is unsheltered location, provide details (i.e., in car at Walmart parking lot)- and proceed with Q6.]	<i>N/A</i>	Location where sleeping tonight: If unsheltered location, provide details:	Location where sleeping tonight: If unsheltered location, provide details:	Location where sleeping tonight: If unsheltered location, provide details:	Location where sleeping tonight: If unsheltered location, provide details:
6. How old are you (Person 1) or Person ____ (Person 2-5)?	Age:	Age:	Age:	Age:	Age:
<i>If hesitant, ask: Are you...?</i>	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25 + <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25 + <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25 + <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25 + <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25 + <input type="checkbox"/> DK/REF

	Person 1	Person 2	Person 3	Person 4	Person 5
7. What is your gender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Don't identify as male, female, or transgender <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Don't identify as male, female, or transgender <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Don't identify as male, female, or transgender <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Don't identify as male, female, or transgender <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Male <input type="checkbox"/> Transgender Female <input type="checkbox"/> Don't identify as male, female, or transgender <input type="checkbox"/> DK/REF
8. Are you Hispanic or Latino?	<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
9. What is your race? You can select one or more races. <i>[Read categories]</i>	<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"/> Other- 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"/> Other- 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"/> Other- 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"/> Other- 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"/> Other- please specify: _____ <input type="checkbox"/> DK/REF
10. Have you served in the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)?	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to Q11]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to Q11]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to Q11]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to Q11]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to Q11]</i> <input type="checkbox"/> DK/REF
<i>[If Q10=No, ask Q11, otherwise go to Q12]</i> 11. Were you ever called into active duty as a member of the National Guard or as a Reservist?	<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

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	Person 1	Person 2	Person 3	Person 4	Person 5
12. Have you ever received health care or benefits from a Veterans Administration medical center?	<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
13a. On what date did you become homeless this time? (Only include time spent staying in shelters and/or on the streets.)	Month/Year: ____ / ____	Month/Year: ____ / ____	Month/Year: ____ / ____	Month/Year: ____ / ____	Month/Year: ____ / ____
13b. Including this time, how many separate times have you stayed in shelters or on the streets in the past 3 years, that is since January 2015?	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF
13c. In total, how long did you stay in shelters or on the streets for those times? <i>[Enter days or weeks or months or years]</i>	_____ 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
14. Do any of the following situations keep you from holding a job or living in stable housing?	<input type="checkbox"/> (a) Alcohol use <input type="checkbox"/> (b) Drug use <input type="checkbox"/> (c) Chronic health condition <input type="checkbox"/> (d) HIV/AIDS <input type="checkbox"/> (e) Mental disability <input type="checkbox"/> (f) Physical disability <input type="checkbox"/> (g) Developmental delay	<input type="checkbox"/> (a) Alcohol use <input type="checkbox"/> (b) Drug use <input type="checkbox"/> (c) Chronic health condition <input type="checkbox"/> (d) HIV/AIDS <input type="checkbox"/> (e) Mental disability <input type="checkbox"/> (f) Physical disability <input type="checkbox"/> (g) Developmental delay	<input type="checkbox"/> (a) Alcohol use <input type="checkbox"/> (b) Drug use <input type="checkbox"/> (c) Chronic health condition <input type="checkbox"/> (d) HIV/AIDS <input type="checkbox"/> (e) Mental disability <input type="checkbox"/> (f) Physical disability <input type="checkbox"/> (g) Developmental delay	<input type="checkbox"/> (a) Alcohol use <input type="checkbox"/> (b) Drug use <input type="checkbox"/> (c) Chronic health condition <input type="checkbox"/> (d) HIV/AIDS <input type="checkbox"/> (e) Mental disability <input type="checkbox"/> (f) Physical disability <input type="checkbox"/> (g) Developmental delay	<input type="checkbox"/> (a) Alcohol use <input type="checkbox"/> (b) Drug use <input type="checkbox"/> (c) Chronic health condition <input type="checkbox"/> (d) HIV/AIDS <input type="checkbox"/> (e) Mental disability <input type="checkbox"/> (f) Physical disability <input type="checkbox"/> (g) Developmental delay

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<p>15. Have you/Has Person [2-5] ever received special education services for more than 6 months?</p> <p><i>[If Q15= Yes, then re-visit Q14 to make sure all applicable boxes have been checked]</i></p>	<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
<p>16. Do you/Does Person [2-5] receive any disability benefits such as Social Security Income, Social Security Disability Income, or Veteran’s Disability Benefits?</p> <p><i>[If Q16= Yes, then re-visit Q14 to make sure all applicable boxes have been checked]</i></p>	<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
<p>17. Are you currently fleeing or experiencing physical, emotional, or sexual abuse by a relative or another person you have stayed with, such as a spouse, partner, brother or sister, or parent?</p>	<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

Thanks for taking the survey!