



# SHELTERED COUNT FORM

Use on: January 21, 2020

Use for: Sheltered Count Interview (Non-HMIS Participating Providers)

## Sheltered Count Form - Ohio BoSCoC 2020 Point-in-Time Count

### Shelter Information:

Location where interview was completed: \_\_\_\_\_ 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]

<b>1. Did another survey worker already ask you these same questions about where you are staying tonight?</b>	<input type="checkbox"/> Yes → [Thank respondent for their time, end the survey] <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Refused				
<b>2. 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>	_____ number of respondents age 55 and older _____ number of respondents age 25-54 _____ number of respondents age 18-24 _____ number of respondents age 17 and younger				
	<b>Person 1</b>				
<b>3a. What is your name? (Person 1)</b> <i>[If respondent says Don't Know or Refused write DK or REF]</i>		<b>Person 2</b>	<b>Person 3</b>	<b>Person 4</b>	<b>Person 5</b>
<b>3b. What are the names of other people in your household from oldest to youngest?</b> <i>[If respondent says Don't Know or Refused write DK or REF]</i>					

**Sheltered Count Form**

**Person #1 Initials: \_\_\_\_\_**

*[Complete the column for Person 1 by asking Q4-Q14. Then complete the columns for Persons 2-5 for all other household members in order of oldest to youngest, by asking Q4-Q14 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
<b>4. How is Person ____ (Person 2-5) related to you (Person 1)?</b>	<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
<b>5. Just to confirm, are you staying with ____ (Person 1) here, in this location, tonight?</b>	<i>N/A</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No →[Go to 5a] <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No →[Go to 5a] <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No →[Go to 5a] <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No →[Go to 5a] <input type="checkbox"/> DK/REF
<i>[If Q5=No, ask Q5a, otherwise go to Q6]</i> <b>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.]</b>	<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:
<b>6. What is your date of birth?</b>	DOB:	DOB:	DOB:	DOB:	DOB:
<i>If hesitant, ask: Are you...?</i>	<input type="checkbox"/> Under 5 <input type="checkbox"/> 5-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-61 <input type="checkbox"/> 62+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 5 <input type="checkbox"/> 5-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-61 <input type="checkbox"/> 62+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 5 <input type="checkbox"/> 5-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-61 <input type="checkbox"/> 62+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 5 <input type="checkbox"/> 5-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-61 <input type="checkbox"/> 62+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 5 <input type="checkbox"/> 5-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-61 <input type="checkbox"/> 62+ <input type="checkbox"/> DK/REF

**Sheltered Count Form**

**Person #1 Initials: \_\_\_\_\_**

	Person 1	Person 2	Person 3	Person 4	Person 5
<b>7. What is your gender?</b>	<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
<b>8. 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>9. What is your race? You can select one or more races.</b>  <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
<b>10. Are you a veteran of 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>11a. Is this the first time you've experienced homelessness?</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

**Sheltered Count Form**

**Person #1 Initials: \_\_\_\_\_**

<b>11b. How many months have you been experiencing homelessness this time?</b>	_____ Months	_____ Months	_____ Months	_____ Months	_____ Months
<b>11c. How many months did you stay in shelters or on the streets during the past 3 years (since January 2017)?</b>	_____ Months	_____ Months	_____ Months	_____ Months	_____ Months
<b>11d. How many separate times have you stayed in shelters or on the streets in the past 3 years (since January 2017)?</b>	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF
<b>12. Do any of the following situations keep you from holding a job or living in stable housing?</b>	<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
<b>13. Do you/Does Person [2-5] receive any disability benefits such as Social Security Income, 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>14. 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?</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

**Thanks for taking the survey!**