



SHELTERED COUNT FORM

Use on: January 24, 2023

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

Sheltered Count Form - Ohio BoSCoC 2023 Point-in-Time Count

Shelter Information:

Location where interview was completed (Project Name): _____ 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. Have you already been interviewed today for the Point in Time Count?	<input type="checkbox"/> Yes → [Thank respondent for their time, end the survey] <input type="checkbox"/> No				
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>	_____ 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				
3a. What is your name or initials? [If respondent says Don't Know or Refused write DK or REF]	Person 1	Person 2	Person 3	Person 4	Person 5
3b. What are the names 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-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
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 <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
6. What is your date of birth?	DOB:	DOB:	DOB:	DOB:	DOB:
<i>If hesitant, ask: Are you...?</i>	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+ <input type="checkbox"/> DK/REF	<input type="checkbox"/> Under 18 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+ <input type="checkbox"/> DK/REF
7. What is your gender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Questioning <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

	Person 1	Person 2	Person 3	Person 4	Person 5
8. Are you Hispanic or Latin(a)(o)(x)?	<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, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other- please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other- please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other- please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other- please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other- please specify: _____ <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
10. Are you a veteran of the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
11a. Is this the first time you've experienced homelessness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

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<p>11b. How long have you been homeless <u>this time</u>? (Only include time spent staying in shelters and/or on the streets.)</p>	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more
<p>11c. How many months did you stay in shelters or on the streets over the <u>past 3 years</u>, that is since January 2020?</p>	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years <input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more
<p>11d. In total, how many separate times have you stayed in shelters or on the streets in the past 3 years (since January 2020)?</p>	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Fewer than 4 <input type="checkbox"/> 4 or more times <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<p>12. Do you struggle with one or more of the following?</p>	<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
<p>13. Do any of the above situations keep you from holding a job or living in stable housing?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
<p>14. 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>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused

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15. 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
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Thanks for taking the survey!