



UNSHELTERED COUNT FORM

Use on: January 24, 2023 8:00pm - 6:00am

Use for: Street Count Interview

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

Address where interview was completed: _____ County: _____

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

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]

<p>1. Where are you sleeping tonight?</p> <p><i>[Do not read categories. Select only one category]</i></p>	<ul style="list-style-type: none"> <input type="checkbox"/> Street or sidewalk <input type="checkbox"/> Vehicle (car, van, RV, truck) <input type="checkbox"/> Park <input type="checkbox"/> Abandoned building <input type="checkbox"/> Bus, train station, airport <input type="checkbox"/> Under bridge/overpass <input type="checkbox"/> Woods or outdoor encampment <input type="checkbox"/> Other location (specify): _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Emergency shelter <input type="checkbox"/> Transitional housing <input type="checkbox"/> Motel/hotel (paid for with public/private funds) <input type="checkbox"/> House or apartment <input type="checkbox"/> Jail, hospital, treatment program <p style="text-align: right;"><i>[Thank respondent for their time, end survey]</i></p>
<p>1a. Enter the physical or geographic location AND address where the person is sleeping tonight.</p>	<p><i>For example, "under Main Street Bridge" and "123 N. High St".</i></p> <p>*Must be enough detail to enter location into app</p>	
<p>2. Did another survey worker already ask you these same questions about where you are staying tonight?</p>	<ul style="list-style-type: none"> <input type="checkbox"/> Yes → [Thank respondent for their time, end the survey] <input type="checkbox"/> No <input type="checkbox"/> Don't Know/Refused 	
<p>3. Including yourself, how many people and children are there in your household, who are sleeping in the same location with you tonight?</p>	<p>_____ number of respondents age 55 and older</p> <p>_____ number of respondents 25-54</p> <p>_____ number of respondents 18-24</p> <p>_____ number of respondents 17 and younger</p>	

Unsheltered Count Form

Person #1 Initials: _____

	Person 1				
4a. What is your name? Initials are fine too. (Person 1) <i>[If respondent says Don't Know or Refused write DK or REF]</i>			Person 2	Person 3	Person 4
4b. What are the names or 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>					

[Complete the column for Person 1 by asking Q5-Q15. Then complete the columns for Persons 2-5 for all other household members in order of oldest to youngest, by asking Q5-Q15 for each person individually (some questions may pertain only to persons age 18 and older). If the other household members are not present, Person 1 should answer for them.]

	Person 1	Person 2	Person 3	Person 4	Person 5
5. 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
6. 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 6a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 6a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 6a]</i> <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No → <i>[Go to 6a]</i> <input type="checkbox"/> DK/REF
<i>[If Q6=No, ask Q6a, otherwise go to Q7]</i> 6a. Where are you staying tonight? <i>[Use categories from Q1; write answer here. If response is unsheltered location, provide exact location- see Q1a- and proceed with Q7. If response is sheltered location, stop and go back to Q6 for next person.]</i>	<i>N/A</i>	Location where sleeping tonight (refer to Q1): If unsheltered location, provide details (refer to Q1a):	Location where sleeping tonight (refer to Q1): If unsheltered location, provide details (refer to Q1a):	Location where sleeping tonight (refer to Q1): If unsheltered location, provide details (refer to Q1a):	Location where sleeping tonight (refer to Q1): If unsheltered location, provide details (refer to Q1a):

Unsheltered Count Form

Person #1 Initials: _____

	Person 1	Person 2	Person 3	Person 4	Person 5
7. 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
8. 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
9. Are you Hispanic or Latin(a)(o)(x)?	<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
10. 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"/> 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"/> 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"/> 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"/> 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

Unsheltered Count Form

Person #1 Initials: _____

	Person 1	Person 2	Person 3	Person 4	Person 5
	<input type="checkbox"/> Other- please specify: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Other- please specify: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Other- please specify: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Other- please specify: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused	<input type="checkbox"/> Other- please specify: <hr/> <input type="checkbox"/> Don't Know <input type="checkbox"/> Refused
11. 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
12. 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
13. How long have you been homeless <u>this time</u>? (Only include time spent staying in shelters and/or on the streets.)	<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
	<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"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years	<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"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years	<input type="checkbox"/> 0-3 months <input type="checkbox"/> 4-6 months <input type="checkbox"/> 7-11 months <input type="checkbox"/> 1-2 years

Unsheltered Count Form

Person #1 Initials: _____

	Person 1	Person 2	Person 3	Person 4	Person 5
14. How many months did you stay in shelters or on the streets over the <u>past 3 years</u>, that is since January 2020?	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more	<input type="checkbox"/> 2-3 years <input type="checkbox"/> 3 years or more
15. In total, how many separate times have you stayed in shelters or on the streets in the past 3 years? (since January 2020)?	<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
16. Do you struggle with one or more of the following?	<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
17. Do any of the above situations keep you from holding a job or living in stable housing?	<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
18. Do you receive any disability benefits such as Social Security Income, Social Security Disability Income, or Veteran's Disability Benefits? <i>[If Q18= Yes, then re-visit Q16 to make sure all applicable boxes have been checked]</i>	<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
19. Are you currently experiencing homelessness because you are fleeing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know

Unsheltered Count Form

Person #1 Initials: _____

	Person 1	Person 2	Person 3	Person 4	Person 5
domestic violence, dating violence, sexual assault, or stalking?	<input type="checkbox"/> Refused	<input type="checkbox"/> Refused	<input type="checkbox"/> Refused	<input type="checkbox"/> Refused	<input type="checkbox"/> Refused
Can I offer a shelter bed or motel/hotel stay to you? If not, thanks for taking the survey! <input type="checkbox"/> Shelter offered and accepted <input type="checkbox"/> Shelter offered and declined					