

COUNTY: \_\_\_\_\_

**2017 PA Balance of State: Unsheltered Point-in-Time Survey of the Homeless – 01/25/2017**  
**\*\*\*\*\* FORM FOR STREET-BASED COUNT CONDUCTED ON WEDNESDAY NIGHT \*\*\*\*\***

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**INTRODUCTION**

- Introduce yourself by your first name and politely ask for 5-10 minutes of time.
- Inform the individual/household, “We are conducting a simple survey of people who are currently experiencing housing challenges. Your participation will help us to identify the need for additional housing and services.”
- “I will ask for your initials and date of birth, as well as other information, but I do not need your name, social security number, or any other information that could be traced back to you.”
- If the individual refuses to be interviewed, say “thank you,” and complete an “Observation Only” form.

**INTERVIEW QUESTIONS**

1. Did anyone else already complete this interview form with you last night or earlier today?  Yes (please discontinue the survey)  No
2. Where will you sleep tonight? (Tonight through Thursday morning)

**UNSHELTERED LOCATIONS:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Street / sidewalk        | <input type="checkbox"/> Vehicle                           | <input type="checkbox"/> Abandoned building            |
| <input type="checkbox"/> Under bridge / over pass | <input type="checkbox"/> Tent / camper / hunting structure | <input type="checkbox"/> Woods / outdoors / encampment |
| <input type="checkbox"/> Bus / train station      | <input type="checkbox"/> Park                              | <input type="checkbox"/> Behind shopping center        |
| <input type="checkbox"/> Other. → Specify: _____  |  |  |

**SHELTERED LOCATIONS:**

- Emergency Shelter. Name of shelter: \_\_\_\_\_
- In a hotel/motel/rent-a-room: If yes, who paid for the room?
- |   |                                 |  |   |                                     |
|---|---------------------------------|--|---|-------------------------------------|
| <input type="checkbox"/> Self / friend / family | <input type="checkbox"/> church | <input type="checkbox"/> charitable/service organization | <input type="checkbox"/> government program | <input type="checkbox"/> Don't know |
|---|---------------------------------|--|---|-------------------------------------|
- Name of organization providing assistance (if applicable/known): \_\_\_\_\_

**OTHER LOCATIONS:**

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> In the home of a family member or friend | <input type="checkbox"/> In a home that I own/rent | <input type="checkbox"/> Other: _____ |
|---|--|---------------------------------------|

3. Please provide me with the following information for each household member sleeping in the same location as you last night: (Attach additional forms if more than 5 persons in Household.)

Person		# 1 Initials: _____	# 2 Initials: _____	# 3 Initials: _____	# 4 Initials: _____	# 5 Initials: _____
<b>NOTE to Interviewer:</b> If an answer to these questions is not provided, please select a response based on your observation.	Age	Date of Birth: _____  If estimating age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-24 years <input type="checkbox"/> 25-59 years <input type="checkbox"/> 60+ years	Date of Birth: _____  * If estimating age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-24 years <input type="checkbox"/> 25-59 years <input type="checkbox"/> 60+ years	Date of Birth: _____  * If estimating age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-24 years <input type="checkbox"/> 25-59 years <input type="checkbox"/> 60+ years	Date of Birth: _____  * If estimating age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-24 years <input type="checkbox"/> 25-59 years <input type="checkbox"/> 60+ years	Date of Birth: _____  * If estimating age: <input type="checkbox"/> Under 18 years <input type="checkbox"/> 18-24 years <input type="checkbox"/> 25-59 years <input type="checkbox"/> 60+ years
	Gender	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as any of the above	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as any of the above	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as any of the above	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as any of the above	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as any of the above
	Ethnicity	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino
	What is your race?  Select <u>all</u> that apply.	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black or African-American <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Native Hawaiian or Pacific Islander
When did you last sleep in one of the following locations: ➤ house or apartment, regardless of ownership or who else lived there? ➤ hotel room paid for by you, family or friends?		<input type="checkbox"/> < 1 week ago <input type="checkbox"/> _____ weeks ago <input type="checkbox"/> _____ months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/refused	<input type="checkbox"/> < 1 week ago <input type="checkbox"/> _____ weeks ago <input type="checkbox"/> _____ months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/refused	<input type="checkbox"/> < 1 week ago <input type="checkbox"/> _____ weeks ago <input type="checkbox"/> _____ months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/refused	<input type="checkbox"/> < 1 week ago <input type="checkbox"/> _____ weeks ago <input type="checkbox"/> _____ months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/refused	<input type="checkbox"/> < 1 week ago <input type="checkbox"/> _____ weeks ago <input type="checkbox"/> _____ months ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/refused

(Continued)	# 1 Initials: _____	# 2 Initials: _____	# 3 Initials: _____	# 4 Initials: _____	# 5 Initials: _____
In the past three years, how many different periods of time have you slept in an emergency shelter, on the street, in a car, in the woods, or any other location identified as “unsheltered” in question 1?	<input type="checkbox"/> 1 (only this time) <input type="checkbox"/> 2 – 3 times <input type="checkbox"/> 4+ times <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 (only this time) <input type="checkbox"/> 2 – 3 times <input type="checkbox"/> 4+ times <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 (only this time) <input type="checkbox"/> 2 – 3 times <input type="checkbox"/> 4+ times <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 (only this time) <input type="checkbox"/> 2 – 3 times <input type="checkbox"/> 4+ times <input type="checkbox"/> Don't know/ Refused	<input type="checkbox"/> 1 (only this time) <input type="checkbox"/> 2 – 3 times <input type="checkbox"/> 4+ times <input type="checkbox"/> Don't know/ refused
(IF 4+ TIMES HOMELESS) In the past three years, how many total months have you have slept in a shelter, on the street, in a car, in the woods, or any other location identified as “unsheltered” in question 1?	<input type="checkbox"/> 1 – 11 months <input type="checkbox"/> 12+ months <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 – 11 months <input type="checkbox"/> 12+ months <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 – 11 months <input type="checkbox"/> 12+ months <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> 1 – 11 months <input type="checkbox"/> 12+ months <input type="checkbox"/> Don't know/ Refused	<input type="checkbox"/> 1 – 11 months <input type="checkbox"/> 12+ months <input type="checkbox"/> Don't know/ refused
Did you serve in <b>ACTIVE DUTY</b> as a member of the Army, Navy, Marine Corp, Air Force, Coast Guard, National Guard or Reserves?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused
Did you serve in the military, but are not eligible for healthcare or benefits from the Veterans Administration?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know/ refused

**IF VETERAN** (meaning responded yes to either of the above two service related questions) ask the following question:

Would you like the name of someone who works with veterans to provide housing resources?

If yes, direct this veteran to the **VA's National Call Center for Homeless Veterans at 1-877-4AID-VET**

<p>Have you ever had trouble maintaining your housing or holding down a job because of –</p> <p>➤ severe mental illness or emotional impairment? (This <i>may</i> include an impairment caused by alcohol or drug use, PTSD or brain injury)</p> <p>➤ alcohol or drugs?</p> <p>➤ physical disability?</p>	<input type="checkbox"/> Severe mental illness or emotional impairment <input type="checkbox"/> Alcohol or drugs <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above	<input type="checkbox"/> Severe mental illness or emotional impairment <input type="checkbox"/> Alcohol or drugs <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above	<input type="checkbox"/> Severe mental illness or emotional impairment <input type="checkbox"/> Alcohol or drugs <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above	<input type="checkbox"/> Severe mental illness or emotional impairment <input type="checkbox"/> Alcohol or drugs <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above	<input type="checkbox"/> Severe mental illness or emotional impairment <input type="checkbox"/> Alcohol or drugs <input type="checkbox"/> Physical disability <input type="checkbox"/> None of the above
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(Continued)	# 1 Initials: _____	# 2 Initials: _____	# 3 Initials: _____	# 4 Initials: _____	# 5 Initials: _____
Have you been diagnosed as having a developmental disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with AIDS or tested positive for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you receive any disability benefits such as SSI, SSDI, or Veteran's Disability Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been in foster care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been in juvenile detention, prison or jail?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been in an inpatient recovery program or residential mental health facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
When you need medical care, where do you typically go?	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Other	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Other	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Other	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Other	<input type="checkbox"/> Doctor's office <input type="checkbox"/> Emergency Room <input type="checkbox"/> Clinic <input type="checkbox"/> Other



**INTERVIEWER: Please only ask the two questions below if the situation appears safe for the respondent.**

Have you ever experienced domestic violence (by a partner or family member)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask
Do you currently lack housing as a result of fleeing domestic violence?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Did not ask

**Is there anything else you want to tell me about your housing experience?**