

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

AGENCY NAME: \_\_\_\_\_

PROGRAM NAME: \_\_\_\_\_

**2023 PA Balance of State: Point-in-Time Survey of the Homeless – 01/25/2023  
Interview Form – EMERGENCY SHELTER**

**Interview Questions**

- Did anyone already complete this interview form with you?  Yes  No
  - If interview administered by someone at this shelter (please discontinue the survey)
  - If interview took place elsewhere - Where? \_\_\_\_\_
- Including yourself, how many adults and children are there in your household, who are sleeping in this shelter tonight? # adults (age 18+) = \_\_\_\_\_ # children (under age 18) = \_\_\_\_\_
- Please provide me with the following information for each household member sleeping in this shelter with you tonight: (Attach additional forms if more than 5 persons in Household.)

**NOTE to Interviewer:** If an answer is not provided for the questions regarding age, please select a response based on your observation.

# 1 Initials: _____	# 2 Initials: _____	# 3 Initials: _____	# 4 Initials: _____	# 5 Initials: _____
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**Please provide the AGE of each Household member.**

Age: _____ If estimating age: <input type="checkbox"/> Under 18 <input type="checkbox"/> 45-54 <input type="checkbox"/> 18-24 <input type="checkbox"/> 55-64 <input type="checkbox"/> 25-34 <input type="checkbox"/> 65 + <input type="checkbox"/> 35-44	Age: _____ If estimating age: <input type="checkbox"/> Under 18 <input type="checkbox"/> 45-54 <input type="checkbox"/> 18-24 <input type="checkbox"/> 55-64 <input type="checkbox"/> 25-34 <input type="checkbox"/> 65 + <input type="checkbox"/> 35-44	Age: _____ If estimating age: <input type="checkbox"/> Under 18 <input type="checkbox"/> 45-54 <input type="checkbox"/> 18-24 <input type="checkbox"/> 55-64 <input type="checkbox"/> 25-34 <input type="checkbox"/> 65 + <input type="checkbox"/> 35-44	Age: _____ If estimating age: <input type="checkbox"/> Under 18 <input type="checkbox"/> 45-54 <input type="checkbox"/> 18-24 <input type="checkbox"/> 55-64 <input type="checkbox"/> 25-34 <input type="checkbox"/> 65 + <input type="checkbox"/> 35-44	Age: _____ If estimating age: <input type="checkbox"/> Under 18 <input type="checkbox"/> 45-54 <input type="checkbox"/> 18-24 <input type="checkbox"/> 55-64 <input type="checkbox"/> 25-34 <input type="checkbox"/> 65 + <input type="checkbox"/> 35-44
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**Please provide the ETHNICITY of each Household member.**

<input type="checkbox"/> Hispanic/ Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/Non- Latin(a)(o)(x)	<input type="checkbox"/> Hispanic/ Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/ Non- Latin(a)(o)(x)	<input type="checkbox"/> Hispanic/ Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/ Non- Latin(a)(o)(x)	<input type="checkbox"/> Hispanic/ Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/ Non- Latin(a)(o)(x)	<input type="checkbox"/> Hispanic/ Latin(a)(o)(x) <input type="checkbox"/> Non-Hispanic/ Non- Latin(a)(o)(x)
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**Please provide the RACE of each Household member. Select all that apply.**

<input type="checkbox"/> White <input type="checkbox"/> Black, African- American, or African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black, African- American, or African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black, African- American, or African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black, African- American, or African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White <input type="checkbox"/> Black, African- American, or African <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Native Hawaiian or Pacific Islander
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**Please provide the GENDER of each Household member.**

<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Questioning	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Questioning	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Questioning	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Questioning	<input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male <input type="checkbox"/> Questioning
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**Instructions:** Please ask all remaining questions to adult household members only and/or a youth under age 18 if they are the Head of Household

**When did you last sleep in one of the following locations:**

house or apartment, regardless of ownership or who else lived there? OR hotel room paid for by you, family or friends?

<input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Less than 1 year ago <input type="checkbox"/> 1+ years ago <input type="checkbox"/> Don't know/ refused
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**In the past three years, during how many different periods of time have you slept in a shelter, on the street, in a car, in the woods/tent, or any other location not intended for sleeping?**

<input type="checkbox"/> 1 (only this time)	<input type="checkbox"/> 1 (only this time)	<input type="checkbox"/> 1 (only this time)	<input type="checkbox"/> 1 (only this time)	<input type="checkbox"/> 1 (only this time)
<input type="checkbox"/> 2 – 3 times	<input type="checkbox"/> 2 – 3 times	<input type="checkbox"/> 2 – 3 times	<input type="checkbox"/> 2 – 3 times	<input type="checkbox"/> 2 – 3 times
<input type="checkbox"/> 4+ times	<input type="checkbox"/> 4+ times	<input type="checkbox"/> 4+ times	<input type="checkbox"/> 4+ times	<input type="checkbox"/> 4+ times
<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused
<b># 1 Initials:</b> _____	<b># 2 Initials:</b> _____	<b># 3 Initials:</b> _____	<b># 4 Initials:</b> _____	<b># 5 Initials:</b> _____

**(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 unsheltered location?**

<input type="checkbox"/> 1 – 11 months	<input type="checkbox"/> 1 – 11 months	<input type="checkbox"/> 1 – 11 months	<input type="checkbox"/> 1 – 11 months	<input type="checkbox"/> 1 – 11 months
<input type="checkbox"/> 12+ months	<input type="checkbox"/> 12+ months	<input type="checkbox"/> 12+ months	<input type="checkbox"/> 12+ months	<input type="checkbox"/> 12+ months
<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused	<input type="checkbox"/> Don't know/ refused

**Instructions:** For reasons of safety, please do not ask the next question in front of two adults who have identified that they are part of the same Household, if two+ adults are being interviewed together, skip this question.

Did you need to leave the place you were last staying due to someone making you feel unsafe? Do you feel unable to return there because you feel unsafe?  Yes  No  Did not ask

**If yes to feeling unsafe,** ask the following question: **Would you like to speak to someone who can talk to you about increasing your safety?** If yes, direct this individual to the **National Domestic Violence Hotline at 1-800-799-7233**

**If yes to feeling unsafe:** Thank you for letting me know. I have a series of additional sensitive questions to ask you. Is that ok, or do you feel like answering additional questions would compromise your safety?

Yes; it is ok to proceed.  No, I am not comfortable answering additional questions (Thank this person and end the survey).

**If safety question not asked, or individual did not indicate feeling unsafe:** The next set of questions asks about sensitive topics. You don't have to answer any question that you don't want to, however your answers will be combined with the answers of other people who take the survey and used to help provide better programs and services to people experiencing homelessness.

**Do you drink alcoholic beverages or use drugs (illegal or prescription for non-medical reasons)?**

<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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**Do you have any mental health conditions (such as depression, anxiety, schizophrenia)?**

<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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**Do you have a physical disability? This could include something that substantially limits one or more basic physical activity such as walking, climbing stairs, reaching, lifting, or carrying?**

<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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**Do any of the situations we just discussed keep you from holding a job or living in stable housing?**

<input type="checkbox"/> Yes: Alcohol/drug	<input type="checkbox"/> Yes: Alcohol/drug	<input type="checkbox"/> Yes: Alcohol/drug	<input type="checkbox"/> Yes: Alcohol/drug	<input type="checkbox"/> Yes: Alcohol/drug
<input type="checkbox"/> Yes: Mental health	<input type="checkbox"/> Yes: Mental health	<input type="checkbox"/> Yes: Mental health	<input type="checkbox"/> Yes: Mental health	<input type="checkbox"/> Yes: Mental health
<input type="checkbox"/> Yes: Physical disab.	<input type="checkbox"/> Yes: Physical disab.	<input type="checkbox"/> Yes: Physical disab.	<input type="checkbox"/> Yes: Physical disab.	<input type="checkbox"/> Yes: Physical disab.
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**Do you have AIDS or an HIV-related illness?**

<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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**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
<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**Did you serve in ACTIVE DUTY 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"/> 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"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused	<input type="checkbox"/> Don't know/refused

**For persons with prior military service,** 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**