

# 2023 POINT IN TIME COUNT – SHELTERED COUNT SURVEY FORM

Jan 2023

Name of Housing Program:	County:
Interviewer:	Email:
Phone:	
Program Type: <input type="checkbox"/> Emergency Shelter (ES) <input type="checkbox"/> Transitional Housing (TH)	

**Note: Mark refusals with an “R” – SURVEYOR, PLEASE DOUBLE CHECK ANSWERS TO MAKE SURE ALL BOXES ARE CHECKED!**

**For Households in ES or on the Streets ONLY (Do not complete for those in TH):** Use Individuals or Head of Households best estimates if not exact.

- |   |   |  |
|---|---|--|
| 1. Have you/your family been living in emergency shelters and/or on the streets continuously for a year or more?          | <input type="checkbox"/> Yes                  | <input type="checkbox"/> No                |
| 2. How many times have you had to stay in emergency shelters and/or on the streets in the past three (3) years?           | <input type="checkbox"/> Fewer than 4         | <input type="checkbox"/> 4 times or more   |
| 3. What was the total amount of time spent in emergency shelters and/or on the streets during these past three (3) years? | <input type="checkbox"/> Fewer than 12 Months | <input type="checkbox"/> 12 Months or More |

➡ ES/TH: Please fill in the following information for the household as well as any family member staying in the same place with the head of household:

Person #1 (you)	Person #2 (not you)	Person #3 (not you)	Person #4 (not you)	Person #5 (not you)
1 <sup>st</sup> 3 letters of First Name:	1 <sup>st</sup> 3 letters of First Name:	1 <sup>st</sup> 3 letters of First Name:	1 <sup>st</sup> 3 letters of First Name:	1 <sup>st</sup> 3 letters of First Name:
1 <sup>st</sup> 3 letters of Last Name:	1 <sup>st</sup> 3 letters of Last Name:	1 <sup>st</sup> 3 letters of Last Name:	1 <sup>st</sup> 3 letters of Last Name:	1 <sup>st</sup> 3 letters of Last Name:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male* <input type="checkbox"/> Questioning	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male* <input type="checkbox"/> Questioning	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male* <input type="checkbox"/> Questioning	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male* <input type="checkbox"/> Questioning	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> A gender other than singularly female or male* <input type="checkbox"/> Questioning
Age: <input type="checkbox"/> 0-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+	Age: <input type="checkbox"/> 0-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+	Age: <input type="checkbox"/> 0-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+	Age: <input type="checkbox"/> 0-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+	Age: <input type="checkbox"/> 0-17 <input type="checkbox"/> 18-24 <input type="checkbox"/> 25-34 <input type="checkbox"/> 35-44 <input type="checkbox"/> 45-54 <input type="checkbox"/> 55-64 <input type="checkbox"/> 65+
<b>Head of Household</b>	Relationship to you: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Family <input type="checkbox"/> Biological/Legal Child <input type="checkbox"/> Friend	Relationship to you: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Family <input type="checkbox"/> Biological/Legal Child <input type="checkbox"/> Friend	Relationship to you: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Family <input type="checkbox"/> Biological/Legal Child <input type="checkbox"/> Friend	Relationship to you: <input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Other Family <input type="checkbox"/> Biological/Legal Child <input type="checkbox"/> Friend
Hispanic or Latin(a), (o), (x): <input type="checkbox"/> Non-Hispanic/Non-Latin(a),(o),(x) <input type="checkbox"/> Hispanic/Latin(a),(o),(x)	Hispanic or Latin(a), (o), (x): <input type="checkbox"/> Non-Hispanic/Non-Latin(a),(o),(x) <input type="checkbox"/> Hispanic/Latin(a),(o),(x)	Hispanic or Latin(a), (o), (x): <input type="checkbox"/> Non-Hispanic/Non-Latin(a),(o),(x) <input type="checkbox"/> Hispanic/Latin(a),(o),(x)	Hispanic or Latin(a), (o), (x): <input type="checkbox"/> Non-Hispanic/Non-Latin(a),(o),(x) <input type="checkbox"/> Hispanic/Latin(a),(o),(x)	Hispanic or Latin(a), (o), (x): <input type="checkbox"/> Non-Hispanic/Non-Latin(a),(o),(x) <input type="checkbox"/> Hispanic/Latin(a),(o),(x)
Race: <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 Pacific Islander. <input type="checkbox"/> White <input type="checkbox"/> Multiple Races	Race: <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 Pacific Islander. <input type="checkbox"/> White <input type="checkbox"/> Multiple Races	Race: <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 Pacific Islander. <input type="checkbox"/> White <input type="checkbox"/> Multiple Races	Race: <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 Pacific Islander. <input type="checkbox"/> White <input type="checkbox"/> Multiple Races	Race: <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 Pacific Islander. <input type="checkbox"/> White <input type="checkbox"/> Multiple Races
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Currently Fleeing Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Fleeing Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Fleeing Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Fleeing Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No	Currently Fleeing Domestic Violence: <input type="checkbox"/> Yes <input type="checkbox"/> No
Disabling Condition(s)? (Check <u>only</u> reported/known:) <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> PTSD <input type="checkbox"/> Brain Injury <input type="checkbox"/> Chronic physical illness/disability	Disabling Condition(s)? (Check <u>only</u> reported/known:) <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> PTSD <input type="checkbox"/> Brain Injury <input type="checkbox"/> Chronic physical illness/disability	Disabling Condition(s)? (Check <u>only</u> reported/known:) <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> PTSD <input type="checkbox"/> Brain Injury <input type="checkbox"/> Chronic physical illness/disability	Disabling Condition(s)? (Check <u>only</u> reported/known:) <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> PTSD <input type="checkbox"/> Brain Injury <input type="checkbox"/> Chronic physical illness/disability	Disabling Condition(s)? (Check <u>only</u> reported/known:) <input type="checkbox"/> Serious Mental Illness <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Substance Use Disorder <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> PTSD <input type="checkbox"/> Brain Injury <input type="checkbox"/> Chronic physical illness/disability

\*A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)

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