

# 2009 Washtenaw County Continuum of Care Point-In-Time Homeless Survey

Please Administer on Thursday, January 29, 2009

## INTERVIEWER ONLY SECTION:

---

*Surveyor's Instructions (not to be read to clients) are italicized throughout the survey. Please ask the person if they have already taken the survey today. If so, do not survey the client.*

1. Interviewer's Name: \_\_\_\_\_ 2. Interview Date: 1/\_\_\_/2009
3. Agency Name: \_\_\_\_\_ 4. Program Name: \_\_\_\_\_
- 5a. Interview Location: *Refers to where the interview/observation is conducted or the type of program completing the survey.*
- |  |  |
|--|--|
| <input type="checkbox"/> Emergency Shelter (ES) Provider Location    | <input type="checkbox"/> Motel (Not ES or TH)                                |
| <input type="checkbox"/> Transitional Housing (TH) Location          | <input type="checkbox"/> Outdoors/Street/Park/Car/Abandoned Building         |
| <input type="checkbox"/> Permanent Supportive Housing (PSH) Location | <input type="checkbox"/> Supportive Services Provider Location (non-housing) |
|  | <input type="checkbox"/> Other (specify) _____                               |
- 5b. Geographic Location: City: \_\_\_\_\_ Township: \_\_\_\_\_ Village: \_\_\_\_\_
6. Interview Method:  Administrative records  Face-to-face  Phone  Observation – person refused survey
- 7a. Is the person currently on a waitlist for housing for homeless people?  YES  NO
- If yes, answer 7b.* Indicate the type of housing (ES, TH, PSH, HARP, etc): \_\_\_\_\_
- 7c. Please indicate the number of days client has been on the waitlist:
- 1-7 days  8-30 days  31- 90 days  90+days
8. This person meets the definition of homelessness according to criteria number\* \_\_\_\_\_. ***Choose ONE.***  
***\* Use Definitions of Homeless from P3 Survey Addendum.***

## SURVEY SECTION

---

*If person refuses to be surveyed, please complete questions 1 – 4b with your best estimate.*  Estimated Answers

1. What is your gender?  Male  Female  Transgendered – Male to Female  Transgendered – Female to Male
2. What is your race?  American Indian/Alaskan Native  Asian  Black/African American  
 Native Hawaiian/Other Pacific Islander  White  Other Multi-Racial  Don't know/Refused
3. Are you Hispanic or Latino?  Yes  No
- 4a. What is your age? \_\_\_\_\_  
*If the person is 17 or under, ask 4b.* Is there a parent or guardian with you?  Yes  No - Unaccompanied Youth  
*If yes, only interview the parent or guardian and discard this survey form. Otherwise, continue survey.*
- 
- Outreach or DV providers: If full name is not available, please enter the first two letters of the client's first and last name.*
- 5a. What is your **First** Name: \_\_\_\_\_ 5b. What is your **Last** Name: \_\_\_\_\_
6. What is your date of birth? (MM/DD/YYYY) \_\_\_\_ / \_\_\_\_ / \_\_\_\_
7. Are you a Veteran?  Yes  No  Don't know/Refused

8. Where are you staying TONIGHT? **Choose ONE.**

- |  |  |
|--|--|
| <input type="checkbox"/> Emergency Shelter (ES)                        | <input type="checkbox"/> Jail, prison or juvenile detention center |
| <input type="checkbox"/> Transitional Housing (TH)                     | <input type="checkbox"/> Living with family members/relatives      |
| <input type="checkbox"/> Permanent Supporting Housing (PSH)            | <input type="checkbox"/> Living with friends                       |
| <input type="checkbox"/> Shelter Assoc. Rotating Shelter               | <input type="checkbox"/> Outside/on the street                     |
| <input type="checkbox"/> Shelter Assoc. Warming Center                 | <input type="checkbox"/> Living in a car/abandoned building        |
| <input type="checkbox"/> Church shelter                                | <input type="checkbox"/> In a motel                                |
| <input type="checkbox"/> Psychiatric hospital or facility              | <input type="checkbox"/> Refused                                   |
| <input type="checkbox"/> Substance abuse treatment center/Detox center | <input type="checkbox"/> Unsure/Don't know                         |
| <input type="checkbox"/> Hospital                                      | <input type="checkbox"/> Other: _____                              |

9. If you have family members with you tonight, please tell us their: name, date of birth, gender and relationship to you.

Person #2 (not you)	Person #3 (not you)	Person #4 (not you)	Person #5 (not you)	Person #6 (not you)
<b>Name**</b> First: _____ Last : _____	<b>Name**</b> First: _____ Last : _____	<b>Name**</b> First: _____ Last : _____	<b>Name**</b> First: _____ Last : _____	<b>Name**</b> First: _____ Last : _____
<b>Date of Birth</b> __/__/__	<b>Date of Birth</b> __/__/__	<b>Date of Birth</b> __/__/__	<b>Date of Birth</b> __/__/__	<b>Date of Birth</b> __/__/__
<b>Age</b>	<b>Age</b>	<b>Age</b>	<b>Age</b>	<b>Age</b>
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender	<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender
<b>Relationship to you:</b> <input type="checkbox"/> Child (under 18) <input type="checkbox"/> Spouse/ Partner <input type="checkbox"/> Other family member describe: _____	<b>Relationship to you:</b> <input type="checkbox"/> Child (under 18) <input type="checkbox"/> Spouse/ Partner <input type="checkbox"/> Other family member describe: _____	<b>Relationship to you:</b> <input type="checkbox"/> Child (under 18) <input type="checkbox"/> Spouse/ Partner <input type="checkbox"/> Other family member describe: _____	<b>Relationship to you:</b> <input type="checkbox"/> Child (under 18) <input type="checkbox"/> Spouse/ Partner <input type="checkbox"/> Other family member describe: _____	<b>Relationship to you:</b> <input type="checkbox"/> Child (under 18) <input type="checkbox"/> Spouse/ Partner <input type="checkbox"/> Other family member describe: _____

**\*\*If any family members are 18 years or over, ask them to complete their own survey as well.**

10. I will read a list of common health conditions of those without a home. Please tell me if any apply to you.

- |                                  |                              |                             |   |
|----------------------------------|------------------------------|-----------------------------|---|
| a. Alcohol abuse                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| b. Developmental disability      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| c. Drug/Substance abuse          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| d. HIV/AIDS and related diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| e. Mental illness                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| f. Physical/Medical disability   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| g. Physical/Mobility Limits      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |
| h. Other disability              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Don't know/Refused |

**If Other disability is yes,** please describe: \_\_\_\_\_

11a. Are you a survivor of domestic violence?  YES  NO  Don't know/Refused

**If yes, ask 11b.** How long ago did you experience domestic violence?

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Within the past 3 mos. | <input type="checkbox"/> 3 to 6 mos. ago | <input type="checkbox"/> From 6 to 12 mos. ago |
| <input type="checkbox"/> More than a yr. ago    | <input type="checkbox"/> Don't know      | <input type="checkbox"/> Refused               |

12. Is the client chronically homeless?  Yes  No  Don't know/Refused

**Answer yes, if client is:** an unaccompanied homeless individual with a disabling condition (1) who has been continuously homeless for a year or more OR who has had at least four episodes of homelessness in the past three years." Homeless episodes must have occurred in emergency shelter or in a place not meant for human habitation (streets, abandoned building, etc).

**Please read this to everyone surveyed:** "Thank you for participating in this survey. If someone else asks you participate in this survey **TODAY**, please tell them that you have already answered these questions for someone else."