

GENERAL INFORMATION/CONSENT

Interviewer's Name		Agency <input type="checkbox"/> TEAM <input type="checkbox"/> STAFF <input type="checkbox"/> VOLUNTEER
Date	Time	Location
In what language do you feel best able to express yourself?		
First Name		Last Name
Nickname		Social Security Number
How old are you?	What's your date of birth?	Has Consented to Participate <input type="checkbox"/> YES <input type="checkbox"/> NO



POINT-IN-TIME COLLECTION

	County: [to be filled out by surveyor]					
1. Where did you sleep on the night of Wednesday January 29? [Do not read categories. Select only one category.]					If in this group go to section A →	<input type="checkbox"/> emergency shelter <input type="checkbox"/> transitional housing <input type="checkbox"/> motel/hotel <input type="checkbox"/> house or apartment <input type="checkbox"/> jail, hospital, treatment program
<input type="checkbox"/> street or sidewalk <input type="checkbox"/> bus, train station, airport <input type="checkbox"/> vehicle (car, van, RV, truck) <input type="checkbox"/> under bridge/overpass <input type="checkbox"/> park <input type="checkbox"/> woods or outdoor encampment <input type="checkbox"/> abandoned building <input type="checkbox"/> other location (specify) _____						
2. Did someone already ask you these same questions about where you were staying on that night?? <input type="checkbox"/> YES <input type="checkbox"/> NO → If YES: Thank them and conclude survey						
Household Information (for the night of Wednesday, January 29 th)						
Including yourself, how many adults and children are there in your household, <u>who slept in the same location with you on January 29th?</u> Adults (age 25+): _____ Adults (age 18-24): _____ Children (under 18): _____ Please list each of these individuals on a line below and mark the associated columns for every member of the household:						
Name	Relationship (spouse/partner/child/etc)	Age	Gender? (M F T)	Veteran? (Y N) -18 & over	Hispanic or Latino? (Y N)	Race: (use key below) A-American Indian or Alaska Native B-Asian C-Black or African American D-Native Hawaiian/Other Pacific Islander E-White F-Don't know
	Self					
3. 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"/> days <input type="checkbox"/> weeks _____ <input type="checkbox"/> months <input type="checkbox"/> years <input type="checkbox"/> refused

A. HISTORY OF HOUSING & HOMELESSNESS

QUESTIONS	RESPONSE	REFUSED
1. What is the total length of time you have lived on the streets or in shelters?		<input type="checkbox"/>
2. In the past three years, how many times have you been housed and then homeless again?		<input type="checkbox"/>



For 100,000 homeless individuals and families



B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when six months ago was, just let me know.

QUESTIONS	RESPONSE		REFUSED
3. In the past six months, how many times have you been to the emergency department/room?			<input type="checkbox"/>
4. In the past six months, how many times have you had an interaction with the police?			<input type="checkbox"/>
5. In the past six months, how many times have you been taken to the hospital in an ambulance?			<input type="checkbox"/>
6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines?			<input type="checkbox"/>
7. In the past six months, how many times have you been hospitalized as an in-patient, including hospitalizations in a mental health hospital?			<input type="checkbox"/>
	YES	NO	REFUSED
8. Have you been attacked or beaten up since becoming homeless?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Threatened to or tried to harm yourself or anyone else in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Does anybody force or trick you to do things that you do not want to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, or anything like that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)	<input type="checkbox"/> Shelter <input type="checkbox"/> Street, Sidewalk or Doorway <input type="checkbox"/> Car, Van or RV <input type="checkbox"/> Bus or Subway <input type="checkbox"/> Beach, Riverbed or Park <input type="checkbox"/> Other (SPECIFY):		

C. SOCIALIZATION & DAILY FUNCTIONS

QUESTIONS	YES	NO	REFUSED
14. Is there anybody that thinks you owe them money?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Do you have any money coming in on a regular basis, like a job or government benefit or even working under the table, binning or bottle collecting, sex work, odd jobs, day labor, or anything like that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Do you have enough money to meet all of your expenses on a monthly basis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have planned activities each day other than just surviving that bring you happiness and fulfillment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do any friends, family or other people in your life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBSERVE ONLY. DO NOT ASK!	YES	NO	
20. Surveyor, do you detect signs of poor hygiene or daily living skills?	<input type="checkbox"/>		<input type="checkbox"/>

D. WELLNESS

QUESTIONS	RESPONSE		
21. Where do you usually go for healthcare or when you're not feeling well?	<input type="checkbox"/> Hospital <input type="checkbox"/> Clinic <input type="checkbox"/> VA <input type="checkbox"/> Other (specify) <input type="checkbox"/> Does not go for care		
<i>Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions:</i>	YES	NO	REFUSED
22. Kidney disease/End Stage Renal Disease or Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. History of frostbite, Hypothermia, or Immersion Foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Liver disease, Cirrhosis, or End-Stage Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. History of Heat Stroke/Heat Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Heart disease, Arrhythmia, or Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBSERVATION ONLY – DO NOT ASK:	<input type="checkbox"/>	<input type="checkbox"/>	
34. Surveyor, do you observe signs or symptoms of a serious health condition?	<input type="checkbox"/>	<input type="checkbox"/>	
35. Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or told you do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Have you consumed alcohol and/or drugs almost every day or every day for the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Have you ever used injection drugs or shots in the last six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. Have you used non-beverage alcohol like cough syrup, mouthwash, rubbing alcohol, cooking wine, or anything like that in the past six months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. Have you blacked out because of your alcohol or drug use in the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBSERVATION ONLY – DO NOT ASK:	<input type="checkbox"/>	<input type="checkbox"/>	
41. Surveyor, do you observe signs or symptoms or problematic alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>	
42. Ever been taken to a hospital against your will for a mental health reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Gone to the emergency room because you weren't feeling 100% well emotionally or because of your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) – REVISED 1/22/2014

44. Spoken with a psychiatrist, psychologist or other mental health professional in the last six months because of your mental health – whether that was voluntary or because someone insisted that you do so?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Had a serious brain injury or head trauma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
46. Ever been told you have a learning disability or developmental disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
47. Do you have any problems concentrating and/or remembering things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
OBSERVATION ONLY – DO NOT ASK: 48. Surveyor, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	<input type="checkbox"/>	<input type="checkbox"/>	
	YES	NO	REFUSED
49. Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Yes or No – Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Finally I'd like to ask you some questions to help us better understand homelessness and improve housing and support services.

Have you ever been physically, emotionally, or sexually abused by a relative or another person you have stayed with, such as a spouse, partner, brother or sister, or parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Do you have a permanent physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Do any of these situations we just discussed keep you from holding a job or living in stable housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Do you receive any disability benefits such as Social Security Income, Social Security Disability Income, or Veteran's Disability Benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
Have you ever served in the US Military?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused
<i>If yes, which war/war era did you serve in?</i>	<input type="checkbox"/> Korean War (June 1950-January 1955) <input type="checkbox"/> Vietnam Era (August 1964-April 1975) <input type="checkbox"/> Post Vietnam (May 1975-July 1991) <input type="checkbox"/> Persian Gulf Era (August 1991-Present) <input type="checkbox"/> Afghanistan (2001-Present) <input type="checkbox"/> Iraq (2003-Present) <input type="checkbox"/> Other (Specify) <input type="checkbox"/> Refused
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	
Ok, now I'd like to take your picture. May I do so?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused

