

TX BoS CoC PIT 1/26/17

Person Conducting Survey: _____ City: _____ Facility/Street Address: _____

Individual does not wish to take the survey or the situation is too dangerous.

1. Initials & Age		Initials ___ M: ___ D: ___ Yr: ___	<input type="checkbox"/> 17 & under (minor)	<input type="checkbox"/> 18 – 24 (youth)	<input type="checkbox"/> 25 - 64	<input type="checkbox"/> 65 & older
2. Where are you sleeping tonight?		<input type="checkbox"/> Emergency shelter (includes DV shelters) <input type="checkbox"/> Transitional housing <input type="checkbox"/> Safe haven <input type="checkbox"/> Hotel or motel paid for with voucher from a church or social services agency <input type="checkbox"/> Place not meant for habitation (street, car, park, tent city, bus station, abandoned building)				
3. How long has this current episode of homelessness lasted?			Years: _____	Months: _____	Days: _____	
4. Which of the following best describes your current situation of homelessness?		<input type="checkbox"/> 1st time in the past 3 years <input type="checkbox"/> 2-3 different times in the past 3 years		<input type="checkbox"/> At least 4 different times in the past 3 years (total time is 12 months or more) <input type="checkbox"/> Continuously Homeless for one year or more		
5. Have you been homeless another time in the past 12 months?				<input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Where were you living when you became homeless <i>this time</i>?				City, State: _____		
7. At what age did you first face homelessness?		<input type="checkbox"/> 17 & under (minor) <input type="checkbox"/> 25 – 64	<input type="checkbox"/> 18 – 24 (youth) <input type="checkbox"/> 65 & older	8. Was your first experience being homeless on your own or with family members?		<input type="checkbox"/> With Family <input type="checkbox"/> On Own
9. Please share the reasons that contributed to why you are experiencing homelessness (Check all that apply)						
<input type="checkbox"/> Unable to pay rent or mortgage <input type="checkbox"/> Loss of public aid <input type="checkbox"/> Natural disaster <input type="checkbox"/> Unemployment <input type="checkbox"/> Moved to seek work <input type="checkbox"/> Evicted <input type="checkbox"/> Physical Health Reasons		<input type="checkbox"/> Family illness <input type="checkbox"/> Divorce or separation <input type="checkbox"/> Pregnant or parenting <input type="checkbox"/> Mental illness <input type="checkbox"/> Substance abuse <input type="checkbox"/> Left jail, prison, or detention <input type="checkbox"/> Domestic Violence		<input type="checkbox"/> Criminal record <input type="checkbox"/> Ran away from home <input type="checkbox"/> Sexual orientation or gender identity <input type="checkbox"/> Aged out of or ran away from foster care <input type="checkbox"/> Kicked out of the house by family/friends <input type="checkbox"/> Other		
10. Gender Identity		<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female, or transgender				
11. Sexual Orientation		<input type="checkbox"/> Gay/lesbian/bisexual <input type="checkbox"/> Straight <input type="checkbox"/> Questioning <input type="checkbox"/> Prefer not to answer				
12. Race		<input type="checkbox"/> White <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> Two or more				
13. Do you consider yourself Hispanic or Latino?			<input type="checkbox"/> Yes		<input type="checkbox"/> No	
14. Are you able to work?		<input type="checkbox"/> Yes <input type="checkbox"/> No (go to #17a)		15. What is your job status?		
		<input type="checkbox"/> Unemployed (go to #16) <input type="checkbox"/> Regular full-time job		<input type="checkbox"/> Regular part-time <input type="checkbox"/> Temporary job <input type="checkbox"/> Day labor/odd jobs <input type="checkbox"/> Retired		
16. If you are unemployed, how long have you been unemployed?				Years: _____	Months: _____	Days: _____
17a. Have you served in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard? (only for age 18 years and older)					<input type="checkbox"/> Yes (go to #17c) <input type="checkbox"/> No	
17b. Were you called into active duty as a member of the National Guard or Reservist? (only for age 18 or older)				<input type="checkbox"/> Yes <input type="checkbox"/> No (go to #18)		
17c. Under what tours of duty have you served? (Check all that apply)			<input type="checkbox"/> Korea <input type="checkbox"/> Kuwait <input type="checkbox"/> Vietnam <input type="checkbox"/> Afghanistan	<input type="checkbox"/> Iraq <input type="checkbox"/> Other	17d. # of Years in Service: _____	
17e. Have you ever received health care or other benefits from the VA Medical Center?					<input type="checkbox"/> Yes <input type="checkbox"/> No	
18. Do you have any of the following health conditions? (Check all that apply)		<input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Physical Disability <input type="checkbox"/> Post-Traumatic Stress Disorder (PTSD)				
		<input type="checkbox"/> Serious Mental illness <input type="checkbox"/> Substance Abuse Disorder <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Traumatic Brain Injury				

19. Which of the following best describes your family/household staying with you today? (Check only one)	
<input type="checkbox"/> Adult or couple without children	<input type="checkbox"/> I am a parenting youth (18 – 24)
<input type="checkbox"/> An unaccompanied youth (age 18 – 24)	<input type="checkbox"/> I am a parenting minor (under 18)
<input type="checkbox"/> An unaccompanied minor (under 18)	<input type="checkbox"/> I am an adult parent in a household with children
	<input type="checkbox"/> Other type of family
20. Have you ever experienced physical or sexual violence while homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No
21. Are you pregnant or an expectant parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No
22. Which of the following services do you need? (Check all that apply)	
<input type="checkbox"/> Basic Needs (Clothing/Food)	<input type="checkbox"/> Food Stamps
<input type="checkbox"/> Job Training/Placement	<input type="checkbox"/> Transportation Assistance
	<input type="checkbox"/> Case Management
	<input type="checkbox"/> Veteran Benefits
	<input type="checkbox"/> Other
For the entries below, only fill out this information if there are additional members of the household.	

Relationship to Head of Household:				
<input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Dependent child <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Legal Guardian <input type="checkbox"/> Other family member				
<input type="checkbox"/> Other non-family member				
Age: <input type="checkbox"/> 17 & under <input type="checkbox"/> 18 – 24 <input type="checkbox"/> 25 – 64 <input type="checkbox"/> 65 & older				
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender <input type="checkbox"/> Don't identify as male, female, or transgender				
Race: <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or other Pacific Islander <input type="checkbox"/> Two or More				
Latino:	Veteran (adults only):	Disability:	<input type="checkbox"/> Phys. Disability	<input type="checkbox"/> Substance Abuse Disorder
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> PTSD	<input type="checkbox"/> Developmental Disability
<input type="checkbox"/> No	<input type="checkbox"/> No	<input type="checkbox"/> Domestic Violence	<input type="checkbox"/> Serious Mental illness	<input type="checkbox"/> Traumatic Brain Injury

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