

Homeless Leadership Coalition - Central Oregon

Hello, my name is _____ and I'm a volunteer with the Homeless Leadership Coalition. We are conducting a survey to count people experiencing homelessness to provide better services to them in our community. Your participation is voluntary and your individual responses will not be shared with anyone outside of our team. I need to read each question all the way through.

May I have a few minutes of your time?

If the person declines to participate, please thank them for their time.

Surveyor MUST fill this out for every survey:	LOCATION: _____
Name of Volunteer Completing Survey: _____	Contact Info: _____

1. *Have you completed this survey earlier this week? Yes (if "Yes", stop survey) No
2. *Please tell me the FIRST letter of your First Name and FIRST 3 letters of your Last Name: ___/_____
3. Where are you planning to stay -OR- where did you stay on the night of (January 23rd, 2019)? SELECT ONE ANSWER

HOMELESS, HOUSELESS, TEMPORARILY HOUSED:

<input type="checkbox"/> In a car, abandoned building, on the street, camping with no RV hook-ups	<input type="checkbox"/> Hotel/ Motel paid for by an agency or organization
<input type="checkbox"/> Emergency shelter (ES)	If ES, name of Facility: _____
<input type="checkbox"/> Transitional housing for homeless (TH)	If TH, name of Facility: _____
<input type="checkbox"/> Temporarily staying with friends or family	<input type="checkbox"/> Other: _____

PERMANENT or OTHER HOUSING (non-homeless) - STOP Survey if any following are chosen.

<input type="checkbox"/> Room, apartment, house rented	<input type="checkbox"/> Apartment or house owned
<input type="checkbox"/> Stayed with family member	<input type="checkbox"/> Stayed with friend
<input type="checkbox"/> Hotel/ Motel paid for by self	<input type="checkbox"/> Foster care home
<input type="checkbox"/> Permanent housing for homeless	<input type="checkbox"/> Don't know
<input type="checkbox"/> Psychiatric facility	<input type="checkbox"/> Substance abuse treatment facility
<input type="checkbox"/> Hospital	<input type="checkbox"/> Jail, prison, detention facility:
<input type="checkbox"/> Refused to answer	If you were not in jail tonight, where would you be sleeping? _____
<input type="checkbox"/> Other: _____	

4. What City are you living in? _____
5. What County do you live in? _____
6. *What is your age in years? _____
7. *Gender Identity: Male Female Transgender M to F Transgender F to M
 Doesn't Identify as M, F or T Two Spirit Refused to Answer
8. Are you Hispanic or Latino? Yes No
9. What is your race? (Please check all that apply): American Indian or Alaskan Native Asian White
 Black or African American Native Hawaiian or Other Pacific Islander Refused/ Unknown
10. How many times have you been on the streets or in an Emergency Shelter in the past three years including today?
 Never in the 3 years One Time Two Times Three Times Four or More Times
11. Total number of months you have been homeless on the street or in an Emergency Shelter in the past three years?
 0 - 3 months 4 - 6 months 7 - 9 months 10 - 11 months 12 Months (1 year) or More
12. How long have you been in homeless this time? 1 Night 2 to 6 Nights
 1 week or more but less than 1 month 1 month or more but less than 3 months
 More than 3 months, but less than 1 year 1 year or longer
13. Where is the last place you had stable housing? Central Oregon (CO) In Oregon (outside CO) Other: _____
14. How long have you lived in Central Oregon? _____
15. What caused you and/or your family to leave your last living arrangement? CHECK ALL THAT APPLY

<input type="checkbox"/> Couldn't afford rent	<input type="checkbox"/> Criminal History	<input type="checkbox"/> Runaway
<input type="checkbox"/> Unemployed	<input type="checkbox"/> Problems at Property	<input type="checkbox"/> Human Trafficking: Sex or Labor
<input type="checkbox"/> Evicted <input type="checkbox"/> No Cause Eviction	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Property Sold
<input type="checkbox"/> Kicked Out by Family/ Friends	<input type="checkbox"/> Mental or Emotional Health Issues	<input type="checkbox"/> Foreclosure
<input type="checkbox"/> Child Abuse	<input type="checkbox"/> Medical Health/ Disability Issues	<input type="checkbox"/> Death in the Family
<input type="checkbox"/> Fleeing Domestic Violence	<input type="checkbox"/> Gender/ Sexual Orientation	<input type="checkbox"/> Natural/ Other Disasters
<input type="checkbox"/> Drug/ Alcohol at Home	<input type="checkbox"/> Discrimination	<input type="checkbox"/> Recent Immigration
<input type="checkbox"/> Drug/ Alcohol (Self)	<input type="checkbox"/> Sexual Abuse/ Rape	<input type="checkbox"/> Other, please specify: _____

16. Do you receive any income? Yes (if yes, check all sources that apply, please) No Income

<input type="checkbox"/> Earned income	<input type="checkbox"/> Unemployment	<input type="checkbox"/> SSA Retirement	<input type="checkbox"/> VA Disability Pension (NON-Service Connected)
<input type="checkbox"/> SSI	<input type="checkbox"/> Alimony	<input type="checkbox"/> Pension/ Retirement Income	
<input type="checkbox"/> SSDI	<input type="checkbox"/> TANF	<input type="checkbox"/> VA Disability Comp (Service Connected)	<input type="checkbox"/> Private Disability Insurance
<input type="checkbox"/> Workers' Comp.	<input type="checkbox"/> Child Support		<input type="checkbox"/> Prefer not to answer
<input type="checkbox"/> General Assistance	<input type="checkbox"/> Other _____		

17. Are there other household members who are homeless and with you now? Yes (please fill out for each person) No

	YOU	INDIVIDUAL 1	INDIVIDUAL 2	INDIVIDUAL 3	INDIVIDUAL 4
a.*1st Initial of First Name/ 1st 3 letters of Last Name		___/_____	___/_____	___/_____	___/_____
b. *Age in Years					
c. *Gender		M/ F/ TMtF/ TFtM/TS/D/R	M/ F/ TMtF/ TFtM/TS/D/R	M/ F/ TMtF/ TFtM/TS/D/R	M/ F/ TMtF/ TFtM/TS/D/R
d. Hispanic or Latino Ethnicity?		Yes/ No	Yes/ No	Yes/ No	Yes/ No
e. *Have any of these individuals been continuously homeless for a year or more?		Yes/ No	Yes/ No	Yes/ No	Yes/ No
f.*Has anyone listed here experienced at least 4 episodes of homelessness in the past 3 years?		Yes/ No	Yes/ No	Yes/ No	Yes/ No
Do any of the following questions apply to you or other household members?					
g. *Veteran (1 or more days of active military service; combat or non-combat)	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
h. *Mental Health Issues	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
i. *Alcoholism	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
j. *Drug Addiction	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
k. *Physical Disability	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
l. *Developmental Disability	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
m. *Persons with HIV/ AIDS	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
n. Survivor of Domestic Violence	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
o. Released Offender (within last 90 days)	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
The following questions are about healthcare access, school attendance and racial identity.					
p. Does anyone listed have health insurance?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
q. In the past 12 months, were you able to get healthcare when you needed it?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
r. Where did you go to get healthcare? (circle all that apply)	ER/ FC/ MV/ UC/ RD/ DA/ IHS	ER/ FC/ MV/ UC/ RD/ DA/ IHS	ER/ FC/ MV/ UC/ RD/ DA/ IHS	ER/ FC/ MV/ UC/ RD/ DA/ IHS	ER/ FC/ MV/ UC/ RD/ DA/ IHS
s. (Only for persons 24 & Under) Are you parenting?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
t. (Only for school age persons; K-12) Are you attending school?	Yes/ No	Yes/ No	Yes/ No	Yes/ No	Yes/ No
Please indicate Race for each Individual - mark all that apply:					
American Indian/ Alaska Native					
Asian					
Black or African American					
Native Hawaiian or Pacific Islander					
White/ Caucasian					
Refused/ Unknown					

Do you need connection to any other resources?