

Please Complete ONE Sheet Per Household

Household Composition:	Complete a column for each household member					
	Individual	Individual	Individual	Individual	Individual	Individual
	1	2	3	4	5	6
1) *Name: First 1 letter of First Name First 3 letters of Last Name	_ / _ _ _	_ / _ _ _	_ / _ _ _	_ / _ _ _	_ / _ _ _	_ / _ _ _
2) *Age: (Age of each household member)						
3) * Gender: (Circle One - M-male, F-female, O - other/don't know/won't disclose)	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O	M / F / O
4)* Have you been continuously homeless for a year or more?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
5)* Have you experienced at least four episodes of homelessness in the past three years?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
6) Length of current episode of homelessness (in months):	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+	<input type="checkbox"/> 0-3 <input type="checkbox"/> 3-6 <input type="checkbox"/> 6-9 <input type="checkbox"/> 9-12 <input type="checkbox"/> 12+
7)* Veteran (18+ Years and US Armed Service or Activated National Guard/Reservist)	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
8) *Severely Mentally Ill	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
9) *Chronic Substance Abuse	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
10) *Physical or Developmental disability	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
11) *Persons with HIV / AIDS	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
12) *Victims of Domestic Violence	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
13) Farmworker	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
14) Released offender (90 days)	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
15) (Only for persons of school age, K-12) Are you attending school?	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No	Yes / No
16) Race / Ethnicity:	Hispanic or Latino					
	American Indian or Alaskan Native					
	Asian					
	Black or African American					
	Native Hawaiian or Pacific Islander					
	White					
	Refused / Unknown / Didn't Ask					
Questions for the whole household						
17) If you are NOT staying at an emergency shelter or in a transitional housing program, where will you stay tonight? (CHECK ONLY ONE)						
<input type="checkbox"/> a. Street <input type="checkbox"/> b. Squatting (Abandoned buildings) <input type="checkbox"/> c. Motel / Hotel <input type="checkbox"/> d. Car <input type="checkbox"/> e. Hospital <input type="checkbox"/> f. Camping <input type="checkbox"/> g. Staying with Friends / Family <input type="checkbox"/> h. Other: _____						
18) 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"/> Poor Rental History <input type="checkbox"/> Homeless By Choice <input type="checkbox"/> Evicted by landlord <input type="checkbox"/> Credit <input type="checkbox"/> Property Sold <input type="checkbox"/> Kicked Out by Family / Friends <input type="checkbox"/> Gambling <input type="checkbox"/> Manufactured Park Closure <input type="checkbox"/> Child Abuse <input type="checkbox"/> Pregnancy <input type="checkbox"/> Home Foreclosed on <input type="checkbox"/> Domestic Violence <input type="checkbox"/> Mental or Emotional Disorder <input type="checkbox"/> Other - Please Specify <input type="checkbox"/> Drug/Alcohol at home <input type="checkbox"/> Medical Problem <input type="checkbox"/> Drug/Alcohol (self)						
Questions for the person filling out the form						
19) Where were the people in this household counted? (CHECK ONLY ONE)						
<input type="checkbox"/> a. Turned Away from Emergency Housing Services <input type="checkbox"/> b. Hotel/Motel/Camp Vouchers <input type="checkbox"/> c. Emergency Shelter <input type="checkbox"/> d. Street Count/Unsheltered <input type="checkbox"/> e. Transitional Housing <input type="checkbox"/> f. Safe Haven						
20) Is this Program Service McKinney-Vento Funded? (Check one) <input type="checkbox"/> Yes <input type="checkbox"/> No						
21) Please review the attached Housing Inventory Chart information, update as necessary and return with this form. <i>Please review the Housing Inventory Chart instructions in the attached cover letter.</i>						
22) CAA or Lead Agency: _____ -Select or Write In-						
23) Program ID: _____ -Select or Write In-						
24) County: _____ -Select or Write In-						
25) City: _____						
26) Person completing this form: _____						