

NJ STATEWIDE CONTINUUM OF CARE POINT IN TIME SURVEY – JANUARY 25, 2012
SAY: Hello, I'm (Name). I'm gathering information on the status of NJ residents. I'd like to ask some questions about your housing and health status.

1. Where will you spend the night of Wednesday, January 25th? (Check ONE only)

<input type="checkbox"/>	On the street, under a bridge, abandoned building, public building, car, traveling on a bus, or camping out
<input type="checkbox"/>	I don't have a permanent dwelling and I don't know where I'll stay
<input type="checkbox"/>	Emergency shelter
<input type="checkbox"/>	Transitional housing (time-limited)
<input type="checkbox"/>	Hotel/motel paid for by agency because you don't have housing
<input type="checkbox"/>	Domestic violence shelter
<input type="checkbox"/>	Youth shelter
<input type="checkbox"/>	Permanent Housing
<input type="checkbox"/>	Temporarily with friends or family
<input type="checkbox"/>	Hotel/motel you paid for while looking for housing
<input type="checkbox"/>	Psychiatric hospital
<input type="checkbox"/>	Jail
<input type="checkbox"/>	Juvenile detention center
<input type="checkbox"/>	Farm labor housing
<input type="checkbox"/>	Medical hospital
<input type="checkbox"/>	Substance abuse treatment facility
<input type="checkbox"/>	Other. Where?

2. In what town will you be spending the night?

Town: _____

County: _____ State: _____

3. Where was your last permanent address before becoming homeless?

Town: _____ County: _____

State: _____ Country: _____

4. How many children (under 18) will be with you tonight?

<input type="checkbox"/>	Number of children 6 years or younger	<input type="checkbox"/>	Number of children 7 – 17 years old
<input type="checkbox"/>	None		
<input type="checkbox"/>	My children are counted on another adult survey		

5. How long have you been homeless?

<input type="checkbox"/>	1 day to 1 week	<input type="checkbox"/>	3 months & 1 day to 6 months
<input type="checkbox"/>	8 days to 1 month	<input type="checkbox"/>	6 months & 1 day to 12 months
<input type="checkbox"/>	1 month & 1 day to 3 months	<input type="checkbox"/>	More than 1 year

6. If you have been homeless more than 1 year, and you have children, have your children been with you the whole time?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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7. If you have been homeless less than 1 year, has there been another time within the past 12 months when you were homeless?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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8. Have you been homeless at least 4 times within the past 3 years (since January 25, 2009)?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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9. If yes and if you have children, were your children with you each time you were homeless?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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10. Which of the following sources of income do you or anyone in your family receive? (Check ALL that apply)

<input type="checkbox"/>	SSI	<input type="checkbox"/>	Unemployment
<input type="checkbox"/>	SSDI	<input type="checkbox"/>	VA Benefits
<input type="checkbox"/>	TANF	<input type="checkbox"/>	Child support
<input type="checkbox"/>	General /Public Assistance/Welfare	<input type="checkbox"/>	Day /Temp work
<input type="checkbox"/>	Medicaid	<input type="checkbox"/>	Food stamps
<input type="checkbox"/>	Medicare	<input type="checkbox"/>	No source of income
<input type="checkbox"/>	Social Security	<input type="checkbox"/>	Receiving NO governmental benefits
<input type="checkbox"/>	Wages	<input type="checkbox"/>	Other: _____

11. What is your income? _____

12. In the last 3 years, have you ever received, are you currently receiving, or would you like to receive, any of the following services?

<i>Service</i>	<i>Received</i>	<i>Need</i>
Mental health services		
Substance use services		
HIV/AIDS services		
Domestic violence		
Medical (disability)		
Veterans services		
Assistance obtaining ID		
Child care		
Dental care		
Educational training		
Emergency food or meal assistance		
Emergency shelter		
Employment assistance		
Housing		
Immigration services		
Legal services		
Medical (routine healthcare)		
Transportation services		
Other:		

13. Have you ever served in the U.S. military?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
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14. What is your ethnicity?

<input type="checkbox"/>	Hispanic or Latino	<input type="checkbox"/>	Not Hispanic or Latino
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15. What category best describes your racial background? (check ALL that apply)

<input type="checkbox"/>	American Indian/ Alaskan Native	<input type="checkbox"/>	Native Hawaiian or Other Pacific Islander
<input type="checkbox"/>	Asian (India, Orient, Middle East)	<input type="checkbox"/>	White
<input type="checkbox"/>	Black	<input type="checkbox"/>	Other

16. What is your sex? (check one)

<input type="checkbox"/>	Male	<input type="checkbox"/>	Female	<input type="checkbox"/>	Transgender
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17. What is your age? _____

18. In the past three years, have you ever been discharged into homelessness from any of the following intuitions?

<input type="checkbox"/>	State prison
<input type="checkbox"/>	City/County Jail
<input type="checkbox"/>	Juvenile Detention Center
<input type="checkbox"/>	Medical Hospital (emergency room, acute medical care)
<input type="checkbox"/>	State Institution for inpatient mental health treatment
<input type="checkbox"/>	City or County institution for inpatient mental health treatment
<input type="checkbox"/>	Private Inpatient Substance Use institution
<input type="checkbox"/>	Foster Care

19. What happened in your life that contributed to or caused your current living situation? (Check ALL that apply)

<input type="checkbox"/>	Alcohol or drug abuse problems
<input type="checkbox"/>	Domestic violence
<input type="checkbox"/>	Eviction or at risk of Eviction
<input type="checkbox"/>	Foreclosure or at risk of Foreclosure
<input type="checkbox"/>	Have work but wages are too low
<input type="checkbox"/>	House condemned
<input type="checkbox"/>	Housing costs are too high
<input type="checkbox"/>	Incarceration
<input type="checkbox"/>	Loss of child support
<input type="checkbox"/>	Lost job/can't find work
<input type="checkbox"/>	Lost job due to lack of transportation
<input type="checkbox"/>	Medical problems/physical or developmental disability
<input type="checkbox"/>	Mental illness/emotional problems
<input type="checkbox"/>	Natural disaster
<input type="checkbox"/>	Relationship/family breakup or death
<input type="checkbox"/>	Utility costs are too high
<input type="checkbox"/>	Other. Describe: _____

20. Identifier:

Last Name (1st 3 Letters): _ | _ | _ **First Initial:** ____

Middle Initial: ____

SAY: Thank you for your time and assistance!