

Springfield-Hampden County Continuum of Care: 2024 Point-in-Time Count – Data Collection Form

We ask some basic identifying information to make sure we don't count the same person more than once. Name OR Initials: _____

Would you please provide your name OR initials? City/Town: _____

Please provide your date of birth. ____/____/____ If the person is reluctant, please request or estimate age: _____
month day year

Where did you sleep the night of **Wednesday, January 31, 2024?**

<input type="checkbox"/> Outdoors <input type="checkbox"/> In a vehicle <input type="checkbox"/> In a bus station, abandoned building, hallway, etc. <input type="checkbox"/> Other: _____	<input type="checkbox"/> Emergency shelter <input type="checkbox"/> Transitional housing <input type="checkbox"/> Hotel, motel <input type="checkbox"/> House or apartment <input type="checkbox"/> With a friend or relative <input type="checkbox"/> Jail, hospital, treatment program If the answer is one of these, STOP here.
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Is this the first time you have been homeless? Yes No Not sure/No comment

How long have you been homeless this time? Only include time spent staying in shelters and/or on the streets. _____ days _____ weeks _____ months _____ years
 Don't know Refused to answer

How many times have you been homeless (in shelter or on the streets) in the last 3 years – since Jan. 2021? 0 1 2 3 4 or more

In total, have you been homeless for 12 months or more in the last 3 years? Yes No Not sure/No comment

How do you describe your gender? (Can select one or more)

<input type="checkbox"/> Woman	<input type="checkbox"/> Man	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)		<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment	

What is your race? (Can select one or more)

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American
<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White
<input type="checkbox"/> Hispanic/Latina/e/o	
<input type="checkbox"/> Not sure/No comment	

Have you served in the United States Armed Forces? Yes No Not sure/No comment

Were you ever called into active duty as a member of the National Guard or a Reservist? Yes No Not sure/No comment

Have you ever received health care or benefits from a Veteran's Admin. Medical Center? Yes No Not sure/No comment

Do you receive benefits such as SSI, SSDI, or Veteran's Disability benefits? Yes No Not sure/No comment

If no SSI/SSDI/Veteran's Disability Benefits: Do you have any type of health issue or disability that interferes with your daily life? This might include traumatic brain injury; acute or chronic illness such as diabetes, heart disease, or cancer; developmental or learning disabilities; or serious physical disability. Yes No Not sure/No comment

Do you have any mental health issues that interfere with your day-to-day life? These might include major depression, schizophrenia, or post-traumatic stress disorder. Yes No Not sure/No comment

Do drugs or alcohol prevent you from maintaining a decent housing situation? Yes No Not sure/No comment

Are you HIV+ or do you have AIDS? Yes No Not sure/No comment

Are you experiencing homelessness because you are currently fleeing domestic violence, dating violence, sexual assault, or stalking? Yes No Not sure/No comment

Were there additional household members sleeping in the same location with you on the night of Wednesday, January 31, 2024? Yes (Please continue on the next page) No (Your survey is complete)

If you want us to contact you again about housing and services, please provide your phone number or location we can find you:

Additional Household members

(Only fill out if you answered "Yes" to the last question on page 1)

Name OR Initials: _____		DOB OR Age: _____			
Additional Household Member 1					
Gender	<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment		
Race (Can select one or more)	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African			
	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Hispanic/Latina/e/o		
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Not sure/No comment		

Name OR Initials: _____		DOB OR Age: _____			
Additional Household Member 2					
Gender	<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment		
Race (Can select one or more)	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African			
	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Hispanic/Latina/e/o		
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Not sure/No comment		

Name OR Initials: _____		DOB OR Age: _____			
Additional Household Member 3					
Gender	<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment		
Race (Can select one or more)	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African			
	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Hispanic/Latina/e/o		
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Not sure/No comment		

Name OR Initials: _____		DOB OR Age: _____			
Additional Household Member 4					
Gender	<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment		
Race (Can select one or more)	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African			
	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Hispanic/Latina/e/o		
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Not sure/No comment		

Name OR Initials: _____		DOB OR Age: _____			
Additional Household Member 5					
Gender	<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)	<input type="checkbox"/> Different Identity	<input type="checkbox"/> Not sure/No comment		
Race (Can select one or more)	<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Black, African American, or African			
	<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Asian or Asian American	<input type="checkbox"/> Hispanic/Latina/e/o		
	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> White	<input type="checkbox"/> Not sure/No comment		