



9. Can you please tell me your First Name? \_\_\_\_\_

10. Can you please share your initials? First: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_ Don't Know/Refused

11. What is your gender? [Interviewer, if "Don't Know/Refuse", make best guess]:

- Male  Female  Transgender Male (Female to Male)  Transgender Female (Male to Female)  
 Gender Non-Conforming/Non-Binary

12. What is your date of birth: Month \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_ Don't Know/Refused

13. How old are you? \_\_\_\_\_ Don't Know/Refused

14. What age range do you fall into? [Interviewer, if "Don't Know/Refuse", make best guess]:

Under 5 \_\_\_\_\_ 6-12 \_\_\_\_\_ 13-17 \_\_\_\_\_ 18-24 \_\_\_\_\_ 25-34 \_\_\_\_\_ 35-44 \_\_\_\_\_ 45-54 \_\_\_\_\_ 55-61 \_\_\_\_\_  
62+ \_\_\_\_\_

15. What is your race? Select all that apply. [Interviewer, if "Don't Know/Refuse/or Other", make best guess based on choices. If respondent answers Bi-racial or Multi-Race, ask if they can specific which ones then select all that apply.]

- White  Black or African American  American Indian or Alaska Native  Asian  
 Native Hawaiian/Pacific Islander

16. Are you Hispanic or Latino? [Interviewer, if "Don't Know/Refuse", make best guess]:

- Yes (Hispanic/Latino)  No (Non-Hispanic/Latino)

17. Is this the first time you have been homeless?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Don't Know/Refused
18. How many months have you been homeless this time? Only include time spent staying in shelters and/or on the streets. <i>[Interviewer: If this is the first time homeless, skip to Q22 after this question is answered.]</i>	Enter number of months (round up to nearest month) _____	<input type="checkbox"/> Don't Know/Refused
19. Including this time, how many times have you been housed and then homeless again where you had to live on the streets or in a shelter in the past three years, so since January 2017? Has it been 4 or more times or less than 4 times? <i>[Interviewer: Ask only if this is NOT the first time homeless.]</i>	<input type="checkbox"/> Less than 4 times <input type="checkbox"/> 4 or more times	<input type="checkbox"/> Don't Know/Refused
20. So, thinking back on all the times you have been homeless in the last 3 years, how many months in total have you had to sleep outside or in an emergency shelter? <i>[Interviewer: Ask only if this is NOT the first time homeless.]</i>	Enter number of months (round up to nearest month) _____	<input type="checkbox"/> Don't Know/Refused

21. In which KY County or Other State were you living in when you became homeless this time?

KY county name: \_\_\_\_\_ Other state name: \_\_\_\_\_ DK/Refused

**22. [INTERVIEWER: SKIP TO Q25 IF THERE IS ONLY ONE PERSON IN THE HOUSEHOLD]**

**I need to ask you some specific questions regarding the other members of your household.**

Persons  HOH = Head of House- hold	Ask and List Relationship to HOH. (spouse, partner, child, other family, other non- family.	<b>Interviewer: Please answer Age, Gender, Race and Ethnicity for each additional household member in order for them to be included in the count. DO NOT SKIP*</b>										
		<b>*AGE*</b>	<b>*GENDER*</b>				<b>*RACE*</b>					<b>*ETHNICITY*</b>
		Age	Male	Female	Transgender	Not Exclusively male or female	White	Black/African-American	Native Hawaiian/Pacific Islander	American Indian or Alaska Native	Multiple	Hispanic/Latino  Circle "Y" for "Yes" "N" for "No"
1: HOH	Self	You have already collected this information for Person 1 (Respondent). Skip to Person 2.										
2											Y N	
3											Y N	
4											Y N	
5											Y N	
6											Y N	

**I have just a few more questions for you (and any other Adults (18+) in the household if applicable)**

<u>ADULTS ONLY (or unaccompanied minor youth)</u>	Person 1 (Self)	Adult 2	Adult 3
<b>23. Do you/this person have any substance abuse issues?</b> [Interviewer: If yes, ask if alcohol, drug, or both]	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Both Alc/Drug <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Both Alc/Drug <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Both Alc/Drug <input type="checkbox"/> No <input type="checkbox"/> DK/R
➤ <b>23a. (If yes), is this substance abuse condition a long-term disability that impairs your/their ability to hold a job or live independently?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>24. Do you/this person have a chronic health condition such as Lupus, Multiple Sclerosis, Hepatitis, etc.</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
➤ <b>24a. (If yes), is this chronic health condition a long-term disability that impairs your/their ability to hold a job or live independently?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>25. Do you/this person have a Mental Health Condition such as PTSD, schizophrenia, or Bipolar Disorder?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
➤ <b>25a. (If yes), is this Mental Health Condition a long-term disability that impairs your/their ability to hold a job or live independently?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R

<b>ADULTS ONLY (unless it is an unaccompanied minor without an adult 18+ in the household)</b>	<b>Person 1 (Self)</b>	<b>Adult 2</b>	<b>Adult 3</b>
<b>26. Do you/this person you have a physical disability?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
➤ <b>26a. (If yes), is this Physical Disability a long-term disability that impairs your/their ability to hold a job or live independently?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>27. Do you/this person have a Developmental Disability such as Cerebral Palsy, Autism, ADHD, or a Traumatic Brain Injury?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>28. Do you/this person receive disability benefits?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>29. Do you/this person have AIDS or an HIV related illness?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>30. Have you/Has this adult ever served in the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard) or have you/they ever been called into Active Duty as part of the National Guard or as a Reservist?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
<b>31. Are you/this person currently employed at a job for which you receive a paycheck?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/R
➤ <b>31a. (If yes), is the employment part-time or full-time?</b>	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> DK/R	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> DK/R	<input type="checkbox"/> Part <input type="checkbox"/> Full <input type="checkbox"/> DK/R

Okay, just a few more questions:

**32. Are you a survivor of domestic violence?**  Yes  No  Don't Know  Refused

**33. Are you currently experiencing homelessness because you are fleeing domestic violence, dating violence, sexual assault, or stalking?**  Yes  No  Don't Know  Refused  
[END SURVEY IF YES] [Go to Q34]

<p><b>34. In your own words, can you tell me what caused you to become homeless this time? [Interviewer: Select all that apply]</b></p>	<input type="checkbox"/> Unemployment/No Job <input type="checkbox"/> Eviction <input type="checkbox"/> Not enough money to afford housing <input type="checkbox"/> Released from jail with nowhere to go <input type="checkbox"/> Released from hospital with nowhere to go <input type="checkbox"/> Family/Personal Reasons <input type="checkbox"/> Aged out of foster care with nowhere to go	<input type="checkbox"/> Runaway/Child Abuse <input type="checkbox"/> Mental Illness <input type="checkbox"/> Chronic Health or Physical Illness/Developmental Disability <input type="checkbox"/> Substance Abuse <input type="checkbox"/> Other (specify below) <hr style="width: 100%;"/>
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Thank you for taking your time to help us. It is very much appreciated