



NORTH DAKOTA UNSHELTERED POINT-IN-TIME COUNT SURVEY
 NORTH DAKOTA CONTINUUM OF CARE
 SFN 61934 (06/24)

*Indicates a required field

Type of Encounter *	
<input type="checkbox"/> Interview	<input type="checkbox"/> Observational (I can't talk to this person)
Where did the encounter occur? * (city and county)	

READ TO EACH RESPONDENT

We are conducting a community-wide survey related to characteristics of people and their housing.

- Participation is completely voluntary.
- If you don't want to take the survey you don't have to answer any questions.
- If you do the survey you can stop, change your mind, or skip questions with no bad consequences.
- Doing or not doing the survey won't change what benefits you qualify for.
- We will keep your participation in this survey confidential.
- The agency responsible for the Point in Time count will make reports from the surveys.
- The surveys don't get shared, then when the reports are done, the surveys are deleted.
- The reports are used for planning and do not include names.
- If you agree to participate, I will read the questions to you and record your answers. It will take approximately 10 minutes to complete.

Have you already been interviewed for this year's Point-in-Time? *	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
First Name of Person Experiencing Homelessness *	Last Name
Where Are (Were) You Sleeping on The Night of The Count (July 10, 2024)? *	
<input type="checkbox"/> On Streets/Homeless Camp/other location not meant for habitation	<input type="checkbox"/> Abandoned Property (not meant for habitation)
<input type="checkbox"/> Vehicle/Car	<input type="checkbox"/> Local Homeless Shelter
<input type="checkbox"/> Friends/Family (Doubled Up)	<input type="checkbox"/> My Apartment/House
<input type="checkbox"/> Hotel/Motel	<input type="checkbox"/> Jail/Institutional Setting
<input type="checkbox"/> Other	
Are (were) you with a household or by yourself? *	If with Household, what is the total number of people in the household?
<input type="checkbox"/> By Myself (Single) <input type="checkbox"/> With Household (Family)	

AGE CATEGORY *

<input type="checkbox"/> Under 18	<input type="checkbox"/> 25-34	<input type="checkbox"/> 45-54	<input type="checkbox"/> 65 and older
<input type="checkbox"/> 18-24	<input type="checkbox"/> 35-44	<input type="checkbox"/> 55-64	<input type="checkbox"/> Refused/Don't Know

GENDER *

<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)
<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
<input type="checkbox"/> Different Identity (specify):	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer

RACE AND ETHNICITY *

<input type="checkbox"/> American Indian, Alaska Native, or Indigenous	<input type="checkbox"/> Asian or Asian American
<input type="checkbox"/> Black, African American, or African	<input type="checkbox"/> Hispanic/Latina/e/o
<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client prefers not to answer	

STATUS*

Number of times you have been homeless (on the streets or in emergency shelters) in the past 3 years? *			
<input type="checkbox"/> 1 (this is the first time)	<input type="checkbox"/> 2-3 times	<input type="checkbox"/> 4 or more times	<input type="checkbox"/> Refused/Don't Know
Add together all the months in the last 3 years during which you spent at least one day on the streets or in emergency shelters *			
<input type="checkbox"/> Fewer than 12	<input type="checkbox"/> 12 or more	<input type="checkbox"/> Refused/Don't Know	
Zip Code of Last Permanent Address *			
<input type="checkbox"/> Zip Code (90 days or more)		<input type="checkbox"/> Refused/Don't Know	
Do you have a disability related to . . . (Mark all that apply) *			
<input type="checkbox"/> None	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical	<input type="checkbox"/> Developmental	
<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Refused/Don't Know	
Are you currently fleeing as a victim of domestic violence? * (Call 911 or local crisis line for help.)			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused/Don't Know	
Have you ever served in the military? *			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused/Don't Know	

If yes, complete the Veterans Supplemental Section at the end of this survey. If the Supplemental Section is completed, this entire survey will be shared with the Veterans Administration.

Additional Notes (if any)

INFORMED CONSENT SIGNATURE

Signature of Respondent	<input type="checkbox"/> Respondent refused signature (no data shared with federal partners)
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I read the consent statement to the respondent and to the best of my knowledge it was understood, and the respondent has agreed to participate.

Surveyor Printed Name	Surveyor Agency Affiliation (if any)
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VETERANS SUPPLEMENTAL SECTION

Veteran Social Security Number ¹	<input type="checkbox"/> Refused/Don't Know
Veteran Date of Birth (mm/dd/yyyy)	<input type="checkbox"/> Refused/Don't Know
Branch of Service <input type="checkbox"/> Air Force <input type="checkbox"/> Marine Corps	<input type="checkbox"/> Army <input type="checkbox"/> Coast Guard
	<input type="checkbox"/> Navy <input type="checkbox"/> Refused/Don't Know
National Guard/Reserve <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Refused/Don't Know

VETERAN CONTACT INFORMATION

Telephone Number	Email Address
Other Contact Information	

¹ The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary, and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

HOUSEHOLD MEMBER'S INFORMATION (1)

First Name of Household Member	Last Name of Household Member
Is this household member a dependent child?	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused/Don't know	

AGE CATEGORY *

<input type="checkbox"/> Under 18	<input type="checkbox"/> 25-34	<input type="checkbox"/> 45-54	<input type="checkbox"/> 65 and older
<input type="checkbox"/> 18-24	<input type="checkbox"/> 35-44	<input type="checkbox"/> 55-64	<input type="checkbox"/> Refused/Don't Know

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<input type="checkbox"/> Middle Eastern or North African	<input type="checkbox"/> Native Hawaiian or Pacific Islander
<input type="checkbox"/> White	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Client prefers not to answer	

STATUS

How long have you been living on the streets or in emergency shelters? *
<input type="checkbox"/> Less than a year <input type="checkbox"/> A year or more <input type="checkbox"/> Refused/Don't Know
Number of times you have been homeless (on the streets or in emergency shelters) in the past 3 years? *
<input type="checkbox"/> 1 (this is the first time) <input type="checkbox"/> 2-3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> Refused/Don't Know
Add together all the months in the last 3 years during which you spent at least one day on the streets or in emergency shelters. *
<input type="checkbox"/> Fewer than 12 <input type="checkbox"/> 12 or more <input type="checkbox"/> Refused/Don't Know
Zip Code of Last Permanent Address *
<input type="checkbox"/> Zip Code (90 days or more) <input type="checkbox"/> Refused/Don't Know
Do you have a disability related to . . . (Mark all that apply) *
<input type="checkbox"/> None <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Mental Health <input type="checkbox"/> Physical <input type="checkbox"/> Developmental
<input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Refused/Don't Know
Are you currently fleeing as a victim of domestic violence? * (Call 911 or local crisis line for help.)
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused/Don't Know
Have you ever served in the military? *
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused/Don't Know

HOUSEHOLD MEMBER'S INFORMATION (2)

First Name of Household Member	Last Name of Household Member	
Is this household member a dependent child?		
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused/Don't know

AGE CATEGORY *

<input type="checkbox"/> Under 18	<input type="checkbox"/> 25-34	<input type="checkbox"/> 45-54	<input type="checkbox"/> 65 and older
<input type="checkbox"/> 18-24	<input type="checkbox"/> 35-44	<input type="checkbox"/> 55-64	<input type="checkbox"/> Refused/Don't Know

GENDER *

<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)
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STATUS*

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Zip Code of Last Permanent Address *			
<input type="checkbox"/> Zip Code (90 days or more)	<input type="checkbox"/> Refused/Don't Know		
Do you have a disability related to . . . (Mark all that apply) *			
<input type="checkbox"/> None	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical	<input type="checkbox"/> Developmental	
<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Refused/Don't Know	
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Have you ever served in the military? *			
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Refused/Don't Know	

HOUSEHOLD MEMBER'S INFORMATION (3)

First Name of Household Member	Last Name of Household Member
Is this household member a dependent child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused/Don't know	

AGE CATEGORY *

<input type="checkbox"/> Under 18	<input type="checkbox"/> 25-34	<input type="checkbox"/> 45-54	<input type="checkbox"/> 65 and older
<input type="checkbox"/> 18-24	<input type="checkbox"/> 35-44	<input type="checkbox"/> 55-64	<input type="checkbox"/> Refused/Don't Know

GENDER *

<input type="checkbox"/> Woman (Girl if child)	<input type="checkbox"/> Man (Boy if child)	<input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit)
<input type="checkbox"/> Transgender	<input type="checkbox"/> Non-Binary	<input type="checkbox"/> Questioning
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HOUSEHOLD MEMBER'S INFORMATION (4)

First Name of Household Member	Last Name of Household Member
Is this household member a dependent child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused/Don't know	

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<input type="checkbox"/> Under 18	<input type="checkbox"/> 25-34	<input type="checkbox"/> 45-54	<input type="checkbox"/> 65 and older
<input type="checkbox"/> 18-24	<input type="checkbox"/> 35-44	<input type="checkbox"/> 55-64	<input type="checkbox"/> Refused/Don't Know

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<input type="checkbox"/> 1 (this is the first time) <input type="checkbox"/> 2-3 times <input type="checkbox"/> 4 or more times <input type="checkbox"/> Refused/Don't Know
Add together all the months in the last 3 years during which you spent at least one day on the streets or in emergency shelters. *
<input type="checkbox"/> Fewer than 12 <input type="checkbox"/> 12 or more <input type="checkbox"/> Refused/Don't Know
Zip Code of Last Permanent Address *
<input type="checkbox"/> Zip Code (90 days or more) <input type="checkbox"/> Refused/Don't Know
Do you have a disability related to . . . (Mark all that apply) *
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