

**Portland Continuum of Care
Wednesday, December 16, 2015
Meeting Minutes**

Aaron Geyer	City of Portland, Health & Human Services Dept., Social Services Division
Jeff Tardif	City of Portland, Health & Human Services Dept., Social Services Division
Angela Giordano	City of Portland, Health & Human Services Dept., Social Services Division
Dawn Stiles	City of Portland, Health & Human Services Dept.
Vickey Rand	Community Housing of Maine
Ginny Dill	Shalom House
Cindy Namer	Maine State Housing Authority
Kelly Watson	Maine State Housing Authority
Wendi DuBois	The Opportunity Alliance
Veronica Ross	The Opportunity Alliance
Jon Bradley	Preble Street
Chet Barnes	State of Maine, Department of Health and Human Services
Alexandra Babcock	MAS Community Health
Beth Clark	

I. Introductions

Jon welcomed everyone and brief introductions were made.

II. HUD Application:

AHAR has been submitted and the remaining piece is being cleaned up by Megan Spencer, Maine Housing, and will be submitted by December 23, 2015.

III. PIT Count:

Cindy Namer presented about PIT and a potential change in methodology to adopt this year. The change consists of a combination “Night of Count” with a Service-Based count methodology. A PIT count would be taken over a 3 day span, focusing on where individuals were on the first night. Cindy passed out example application forms for sheltered and unsheltered individuals, along with the “MCoC’s Resource Committee Recommendations Regarding the 2016 Point In Time Survey” (see attached).

Ginny made a motion to adopt the 3-day methodology as presented and Jon seconded the motion. **MOTION PASSED with all in favor.**

Aaron made a motion to adopt the PIT application forms as presented and Jon seconded the motion. **MOTION PASSED with all in favor.**

Cindy presented the AHAR summary data (see attached). The data showed some significant reductions when comparing FY2015 to FY2014.

IV. Discussion of Collaborative Application for 2017:

There was a lengthy discussion around the collaborative applicant and the City of Portland stepping out of the collaborative applicant role for FY2017. A discussion was had about the best practices for stepping back without disrupting time sensitive tasks in the upcoming year.

A vote via email was decided upon regarding the following recommendation:

The Members of the PCoC, who are on the leadership committee, made a recommendation to nominate Maine Housing as the collaborative applicant for the 2017 application and to allow Maine Housing to communicate with HUD on behalf of the PCoC. In addition, a motion was

made to allow Cindy Namer and Dave MacLean to execute documents as needed to change the collaborative applicant to Maine Housing.

The vote via email would close Monday, December 28, 2015.

- V. VA Technical Assistance:**
No changes or updates.

Next Meeting:
January 20, 2015
9:00 am – 12:00 pm
Refugee Services Conference Area
190 Lancaster Street
Portland, ME 04101

Sign off
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2016 Unsheltered Count Form for Night of Count

Location: _____ Town: _____ Zip Code: _____ County: _____
 Interviewer: _____ Date: _____ Time: _____ AM/PM

Hello, my name is _____ and I'm a volunteer for the [NAME OF COG]. We are conducting a survey to count persons experiencing homelessness to provide better programs and services to them. Your participation is voluntary. The information collected will be entered into the Homeless Management Information System (HMIS) and may be used in a non-identifying manner for statewide statistics and research. Can I have about 10 minutes of your time?

Yes [GO TO Q1] No [THANK RESPONDENT]

<p>1. Where are you sleeping tonight? DO NOT READ CATEGORIES. SELECT ONLY ONE CATEGORY</p>	<p>1. Street or sidewalk 2. Vehicle (car, van, RV, truck) 3. Park 4. Abandoned Building 5. Bus, train station, airport 6. Under bridge/overpass 7. Woods or outdoor encampment 8. Other location (specify) _____</p>	<p>9. Emergency Shelter (including Hotel/Motel paid for with Shelter voucher) 10. Transitional Housing for homeless persons 11. Safe Haven</p> <p>[SAY: YOU WILL BE INCLUDED IN THE COUNT AT THESE LOCATIONS, THANK YOU FOR YOUR TIME.]</p> <p>*IF THE CLIENT IS HOUSED/SHELTERED IN A NON-HMIS PARTICIPATING SHELTER/TRANSITIONAL HOUSING FACILITY OR SAFE HAVEN, GO TO THE BLUE SURVEY FORM</p> <p>*IF THE CLIENT IS NOT LITERALLY HOMELESS, THANK THEM FOR THEIR TIME!</p>
<p>2. Did another volunteer or survey worker already ask you these same questions about where you are staying tonight?</p>	<p><input type="checkbox"/> YES → Thank them for taking the survey <input type="checkbox"/> NO <input type="checkbox"/> CLIENT DOESN'T KNOW/CLIENT REFUSED (DK/REF)</p>	
<p>3. Including yourself, how many adults, and children are there in your household, who are sleeping in the same location with you tonight?</p>	<p>Adults (Age 18 and older) _____ Children (Age 17 and younger) _____ Person 1 _____</p>	
<p>4a. What is your full name? (PERSON 1)</p>	<p>Person 1 _____</p>	
<p>4b. What are the full names of the other people in your household?</p>	<p>Person 2 _____</p>	<p>Person 3 _____</p> <p>Person 4 _____</p> <p>Person 5 _____</p>

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COMPLETE THE COLUMN FOR PERSON 1 BY ASKING Q7-Q22. THEN COMPLETE THE COLUMNS FOR PERSONS 2-5 FOR ALL OTHER HOUSEHOLD MEMBERS BY ASKING Q5-Q22 FOR EACH PERSON. IF OTHER HOUSEHOLD MEMBERS ARE PRESENT, ASK EACH INDIVIDUALLY FOR THEIR ANSWERS TO Q5-22. IF OTHER HOUSEHOLD MEMBERS ARE NOT PRESENT, PERSON 1 SHOULD ANSWER FOR THEM.

	Person 1	Person 2	Person 3	Person 4	Person 5
5. How is [each household member] related to you/person 1?	SELF	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family
6. Just to confirm, are you staying with [person 1] here, in this location tonight? [IF NO, ASK Q6A, OTHERWISE, GO TO Q7]	SKIP FOR PERSON 1]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
2. Where are you staying tonight? [RECORD NUMBER FROM Q1 CHOICES]	SKIP FOR PERSON 1]				
7. What is your date of birth?					
8. Are you male, female, or transgender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF
9. Are you Hispanic or Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
10. What is your race? You can select one or more races. [READ CATEGORIES, DO NOT READ "Please Specify"]	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: _____ <input type="checkbox"/> DK/REF

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11. What is the zip code of your last permanent address? [WHERE THE PERSON(S) LAST LIVED FOR 90 DAYS OR MORE]					
12. Approximately what date did you start staying on the streets, in shelters, or safe haven this time? [INCLUDE TOTAL TIME IN ALL OF THESE LOCATIONS IF THERE WERE NO BREAKS IN HOMELESSNESS]	____/____/____	____/____/____	____/____/____	____/____/____	____/____/____
13. Including this time, how many separate times have you stayed on the streets, in shelters or safe havens, past 3 years, (since January 2013)?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF
14. In total, how many months did you stay on the streets, in shelter, or safe havens during in the past 3 years (since January 2013)?	_____ Months	_____ Months	_____ Months	_____ Months	_____ Months

**INFORM RESPONDANT THAT THEIR RESPONSES TO DISABILITY RELATED QUESTIONS ARE VOLUNTARY AND THAT THEIR REFUSAL TO RESPOND WILL NOT RESULT IN A DENIAL OF SERVICE!

15. Do you/Does Person [2-5] have...	Person 1	Person 2	Person 3	Person 4	Person 5
a. Any ongoing health problems or medical conditions such as diabetes, cancer, heart disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
b. Post-traumatic stress disorder or PTSD? [IF NECESSARY: a condition that can occur in people who have seen or had life threatening events such as natural disasters, serious accidents, war, or personal violence. It may cause feelings of detachment.]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
c. Psychiatric or emotional conditions such as depression or schizophrenia?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

Do you/Does Person [2-5] have... (cont)

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	Person 1	Person 2	Person 3	Person 4	Person 5
d. A Physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
e. A traumatic injury to your/their brain from a bump, blow, or wound to the head?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
h. A substance abuse problem? [IF YES, INDICATE TYPE] [IF YES, ASK j]	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF
i. Have you, (has Person [2-5]) ever been treated for this substance abuse problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
[IF ONE OR MORE ANSWERS FROM A-H = YES, ASK J. IF PERSON HAS NONE OF THESE HEALTH ISSUES, SKIP TO Q16.]					
j. Do any of the situations we just discussed keep you from holding a job or living in stable housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
[IF J = YES, THEN ASK K. IF NOT, SKIP TO QUESTION 16.]					
k. Which one(s) keep you from holding a job or living in stable housing?	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse
16. Do you/Does Person [2-5] have AIDS or HIV-related illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
17. Have You/Has Person [2-5] received special education (or special ed) services for more than 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
18. Have you ever been physically, emotionally, or sexually abused by a relative or another person you have stayed with, such as a spouse, partner, brother or sister, or parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

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** [ONLY ASK QUESTIONS 19 - 22 TO PERSONS 18 AND OLDER] **

	Person 1	Person 2	Person 3	Person 4	Person 5
19. Have you served in the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
[IF Q 19 = NO, ASK Q20, OTHERWISE GO TO Q21] 20. Were you ever called into active duty as a member of the National Guard or as a Reservist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
21. Have you ever received health care or benefits from the Veteran's Administration medical center?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
22. Do you/Does person [2-5] receive any disability benefits such as Social Security Disability Income, or Veteran's Disability Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

Thank you for taking the survey!

2016 Unsheltered Count Form for POST - Night of Count

Location: _____ Town: _____ Zip Code: _____ County: _____
 Interviewer: _____ Date: _____ Time: _____ AM/PM

Hello, my name is _____ and I'm a volunteer for the [NAME OF CoC]. We are conducting a survey to count persons experiencing homelessness to provide better programs and services to them. Your participation is voluntary. The information collected will be entered into the Homeless Management Information System (HMIS) and may be used in a non-identifying manner for statewide statistics and research. Can I have about 10 minutes of your time?

Yes [GO TO Q1] No [THANK RESPONDENT]

1. Where were you sleeping on the night of Wednesday, January 27th?
 [DO NOT READ CATEGORIES. SELECT ONLY ONE CATEGORY]

- 1. Street or sidewalk
- 2. Vehicle (car, van, RV, truck)
- 3. Park
- 4. Abandoned Building
- 5. Bus, train station, airport
- 6. Under bridge/overpass
- 7. Woods or outdoor encampment
- 8. Other location (specify) _____

[GO TO Q2]

- 9. Emergency Shelter (including Hotel/Motel paid for with Shelter voucher)
- 10. Transitional Housing for homeless persons
- 11. Safe Haven

[SAY: YOU WILL BE INCLUDED IN THE COUNT AT THESE LOCATIONS, THANK YOU FOR YOUR TIME.]

*[IF THE CLIENT WAS HOUSED/SHELTERED IN A NON-HMIS PARTICIPATING SHELTER/TRANSITIONAL HOUSING FACILITY OR SAFE HAVEN ON THAT NIGHT, GO TO THE BLUE SURVEY FORM]

*[IF THE CLIENT WAS NOT LITERALLY HOMELESS ON THAT NIGHT, THANK THEM FOR THEIR TIME]

2. Did another volunteer or survey worker already ask you these same questions about where you were staying on that night?

YES → Thank them for taking the survey
 NO
 CLIENT DOESN'T KNOW/CLIENT REFUSED (DK/REF)

3. Including yourself, how many adults, and children were there in your household, who slept in the same location with you on Wednesday?

_____ Adults (Age 18 and older)
 _____ Children (Age 17 and younger)

4a. What is your full name? (PERSON 1)

Person 1

4b. What are the full names of the other people in your household?

Person 2

Person 3

Person 4

Person 5

[COMPLETE THE COLUMN FOR PERSON 1 BY ASKING Q7-Q22. THEN COMPLETE THE COLUMNS FOR PERSONS 2-5 FOR ALL OTHER HOUSEHOLD MEMBERS BY ASKING Q5-Q22 FOR EACH PERSON. IF OTHER HOUSEHOLD MEMBERS ARE PRESENT, ASK EACH INDIVIDUALLY FOR THEIR ANSWERS TO Q5-22. IF OTHER HOUSEHOLD MEMBERS ARE NOT PRESENT, PERSON 1 SHOULD ANSWER FOR THEM.]

(Color: Yellow)

	Person 1	Person 2	Person 3	Person 4	Person 5
5. How is [each household member] related to you/person 1?	SELF	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family	<input type="checkbox"/> Child <input type="checkbox"/> Spouse <input type="checkbox"/> Other Family <input type="checkbox"/> Non-Married Partner <input type="checkbox"/> Other, Non-Family
6. Just to confirm, did you stay with [person 1] on Wednesday, January 27th [IF NO, ASK Q6A, OTHERWISE, GO TO Q7] a. Where were you staying on that night? [RECORD NUMBER FROM Q1 CHOICES]	[SKIP FOR PERSON 1]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
7. What is your date of birth?					
8. Are you male, female, or transgender?	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (Male to Female) <input type="checkbox"/> Transgender (Female to Male) <input type="checkbox"/> DK/REF
9. Are you Hispanic or Latino?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
10. What is your race? You can select one or more races. [READ CATEGORIES, DO NOT READ "Please Specify" ¹]	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: <input type="checkbox"/> DK/REF	<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Other Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Please specify: <input type="checkbox"/> DK/REF

(Color: Yellow)

<p>11. What is the zip code of your last permanent address? [WHERE THE PERSON(S) LAST LIVED FOR 90 DAYS OR MORE]</p>					
<p>12. Approximately what date did you start staying on the streets, in shelters, or safe haven this time? [INCLUDE TOTAL TIME IN ALL OF THESE LOCATIONS IF THERE WERE NO BREAKS IN HOMELESSNESS]</p>	<p>____/____/____</p>	<p>____/____/____</p>	<p>____/____/____</p>	<p>____/____/____</p>	
<p>13. Including this time, how many separate times have you stayed on the streets, in shelters or safe havens, <u>past 3 years</u>, (since January 2013)?</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 or more times <input type="checkbox"/> DK/REF</p>
<p>14. In total, how many months did you stay on the streets, in shelter, or safe havens during in the <u>past 3 years</u> (since January 2013)?</p>	<p>_____ Months</p>	<p>_____ Months</p>	<p>_____ Months</p>	<p>_____ Months</p>	<p>_____ Months</p>

****INFORM RESPONDANT THAT THEIR RESPONSES TO DISABILITY RELATED QUESTIONS ARE VOLUNTARY AND THAT THEIR REFUSAL TO RESPOND WILL NOT RESULT IN A DENIAL OF SERVICE****

15. Do you/Does Person [2-5] have...	Person 1	Person 2	Person 3	Person 4	Person 5
<p>a. Any ongoing health problems or medical conditions such as diabetes, cancer, heart disease?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>
<p>b. Post-traumatic stress disorder or PTSD? [IF NECESSARY: a condition that can occur in people who have seen or had life threatening events such as natural disasters, serious accidents, war, or personal violence. It may cause feelings of detachment.]</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>
<p>c. Psychiatric or emotional conditions such as depression or schizophrenia?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF</p>

(Color: Yellow)

Do you/Does Person [2-5] have... (cont.)

	Person 1	Person 2	Person 3	Person 4	Person 5
d. A Physical disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
e. A traumatic injury to your/their brain from a bump, blow, or wound to the head?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
h. A substance abuse problem? [IF YES, INDICATE TYPE] [IF YES, ASK if]	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF	<input type="checkbox"/> No <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both <input type="checkbox"/> DK/REF
i. Have you, (has Person [2-5]) ever been treated for this substance abuse problem?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
[IF ONE OR MORE ANSWERS FROM A - H = YES, ASK J. IF PERSON HAS NONE OF THESE HEALTH ISSUES, SKIP TO Q16.] j. Do any of the situations we just discussed keep you from holding a job or living in stable housing?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
[IF J = YES, THEN ASK K. IF NOT, SKIP TO QUESTION 16.] k. Which one(s) keep you from holding a job or living in stable housing?	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse	<input type="checkbox"/> Ongoing Health Issue <input type="checkbox"/> PTSD <input type="checkbox"/> Psychiatric/Emotional <input type="checkbox"/> Physical Disability <input type="checkbox"/> Brain Injury <input type="checkbox"/> Substance Abuse
16. Do you/Does Person [2-5] have AIDS or HIV-related illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
17. Have You/Has Person [2-5] received special education (or special ed) services for more than 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
18. Have you ever been physically, emotionally, or sexually abused by a relative or another person you have stayed with, such as a spouse, partner, brother or sister, or parent?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

** [ONLY ASK QUESTIONS 19 - 22 TO PERSONS 18 AND OLDER] **

(Color: Yellow)

	Person 1	Person 2	Person 3	Person 4	Person 5
19. Have you served in the United States Armed Forces (Army, Navy, Air Force, Marine Corps, or Coast Guard)? [IF Q 19 = NO, ASK Q20, OTHERWISE GO TO Q21]	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
20. Were you ever called into active duty as a member of the National Guard or as a Reservist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
21. Have you ever received health care or benefits from the Veteran's Administration medical center?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF
22. Do you/Does person [2-5] receive any disability benefits such as Social Security Disability Income, or Veteran's Disability Benefits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK/REF

Thank you for taking the survey!

2016 ME PTT Collection Form – Non-HMIS Participating Shelters, Transitional Housing, and Safe Havens

PLEASE COMPLETE ONE SHEET FOR EACH PERSON SERVED, WHETHER THEY ARE AN INDIVIDUAL OR A FAMILY MEMBER

Agency: _____ Town: _____ Zip Code: _____

County: _____ Interviewer: _____

Date: _____ Time: _____ AM/PM

“We are conducting a survey to count persons experiencing homelessness to provide better programs and services to them. Your participation is voluntary. The information collected will be used in a non-identifying manner for statewide statistics and research. Can I have about 10 minutes of your time?”

Where are you sleeping tonight/Where were you sleeping on the night of Wednesday, January 27th?
[SELECT ONLY ONE CATEGORY]

- Emergency Shelter _____ Name of Shelter _____
- Transitional Housing for homeless persons _____ Name of Transitional Housing _____
- Safe Haven _____ Name of Safe Haven _____
- Hotel or Motel Paid for By _____ Name of Agency/Organization _____

If part of a Household, Name of Head of Household _____

Relationship to Head of Household _____

First Name: _____ MI: _____ Last Name: _____ Suffix: _____

- Name Type:
- Full Name Reported
 - Partial, Street Name, or Code Name Reported
 - Client Doesn't Know
 - Client Refused
 - Data Not Collected

U.S. Military Veteran? (clients 18 and older): Yes No Client Doesn't Know Client Refused Data Not Collected

DOB(mm/dd/yyyy) ____/____/____ DOB Type:

- Full DOB
- Approximate or Partial DOB
- Client Doesn't Know
- Client Refused
- Data Not Collected

- Primary Race:
- American Indian or Alaska Native
 - Asian
 - Black/African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Client Doesn't know
 - Client Refused
 - Data Not Collected

- Secondary Race:
- American Indian or Alaska Native
 - Asian
 - Black/African American
 - Native Hawaiian or Other Pacific Islander
 - White
 - Client Doesn't know
 - Client Refused
 - Data Not Collected

- Ethnicity:
- Hispanic/Latino
 - Non-Hispanic /Latino)
 - Client Doesn't Know
 - Client Refused
 - Data Not Collected

2016 ME PIT Collection Form - Non-HMIS Participating Shelters, Transitional Housing, and Safe Havens

- Gender: Female Other - If other gender, specify _____
 Male Client Doesn't Know
 Transgender Male to Female Client Refused
 Transgender Female to Male Data Not Collected

Residence Prior to Project Entry:

<i>(choose one)</i>	
<input type="checkbox"/> Emergency Shelter	<input type="checkbox"/> Rental by Client with GPD TIP Subsidy
<input type="checkbox"/> Foster Care Home or Foster Care Group Home	<input type="checkbox"/> Rental by Client with Other Ongoing Housing Subsidy (Non-VASH)
<input type="checkbox"/> Hospital or other Residential Non-Psychiatric Medical Facility	<input type="checkbox"/> Residential Project or Halfway House with no Homeless Criteria
<input type="checkbox"/> Hotel or Motel Paid for without an Emergency Shelter Voucher	<input type="checkbox"/> Safe Haven
<input type="checkbox"/> Jail, Prison or Juvenile Detention Facility	<input type="checkbox"/> Staying or Living in a Family Member's Room, Apartment or House
<input type="checkbox"/> Long-Term Care Facility or Nursing Home	<input type="checkbox"/> Staying or Living in a Friend's Room, Apartment or House
<input type="checkbox"/> Owned by Client, No Ongoing Housing Subsidy	<input type="checkbox"/> Substance Abuse Treatment Facility or Detox Center
<input type="checkbox"/> Owned by Client, with Ongoing Housing Subsidy	<input type="checkbox"/> Transitional Housing for Homeless Persons (includes homeless youth)
<input type="checkbox"/> Permanent Housing for Formerly Homeless Persons	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Place Not Meant for Habitation	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Psychiatric Hospital or Other Psychiatric Facility	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Rental by Client, No Ongoing Housing Subsidy	<input type="checkbox"/> Data Not Collected
<input type="checkbox"/> Rental by Client with VASH Subsidy	

- Length of stay at location selected above: 1 day or less 1 year or longer
 2 days to 1 week Client Doesn't Know
 More than 1 week but less than 1 month Client Refused
 1 to 3 months Data Not Collected
 More than 3 months but less than 1 year

Client Entering from the Streets, Shelter or Safe Haven? Yes No Client Doesn't Know Client Refused DNC

If yes, Approximate Date Started: ____/____/____

Regardless of where they stayed last night - Number of times the clients has been homeless on the streets, in Emergency Shelter, or Safe Haven in the past three years including today:

- Never in the 3 Years Four or More Times
 One Time Client Doesn't Know
 Two Times Client Refused
 Three Times Data Not Collected

Total Number of Months Homeless on the street, in Emergency Shelter or Safe Haven in the Past Three Years

- One Month (this time is the first month) 6 Months 11 Months
 2 Months 7 Months 12 Months
 3 Months 8 Months More than 12 Months
 4 Months 9 Months Client Doesn't Know
 5 Months 10 Months Client Refused
 Data Not Collected

2016 ME PIT Collection Form – Non-HMIS Participating Shelters, Transitional Housing, and Safe Havens

Zip code of last permanent address [WHERE THE CLIENT LAST LIVED FOR 90 DAYS OR MORE]: _____

Zip Code data quality: Full or Partial Client Doesn't Know Client Refused Data Not Collected

**[INFORM RESPONDANT THAT THEIR RESPONSES TO DISABILITY RELATED QUESTIONS ARE VOLUNTARY AND THAT THEIR REFUSAL TO RESPOND WILL NOT RESULT IN A DENIAL OF SERVICE]

Do you have a disabling condition? Yes No Client Doesn't Know Client Refused Data Not Collected

[IF YES, RECORD TYPE AND ANSWER ADDITIONAL QUESTIONS]:

Disability Type	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	Documentation of the disability and severity on file?	Currently Receiving Treatment or Services?
Physical <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Alcohol Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have you ever been a victim of domestic violence? Yes No Client Doesn't Know Client Refused Data Not Collected

If yes, how long ago? Within the past three months More than a year ago
 Three to six months ago Client Doesn't know
 From six to twelve months ago Client Refused

If yes, are you currently fleeing? Yes No Client Doesn't Know Client Refused Data Not Collected

Count Forms:

The Resource Committee recommends that Maine Housing (Collaborative Applicant) retain the responsibility for creating the survey data collection forms and ensuring those forms meet the HUD Point In Time Count standards.

Sheltered Count:

The Resource Committee recommends that the sheltered portion of the annual count continue to be organized and overseen utilizing the same structure/method utilized in previous counts.

Unsheltered Count:

Census vs. Sampling:

The Resource Committee recommends that the Maine Continuum of Care approve a Census (complete coverage) methodology for the count.

Night of Count vs. Service-Based Count:

The Resource Committee recommends that the Maine Continuum of Care approve a combination "Night of Count" with a Service-Based count methodology for the 2016 Point In Time Survey. If the Maine Continuum of Care approves Wednesday, January 27th, 2016 as the date for the Night of the Count, then the Resource Committee recommends that Thursday, January 28th, 2016 and Friday, January 29th, 2016 be the dates approved for the service-based portion of the count

(Please see additional pages for further information on the recommendations made.)

MCoC Resource Committee Recommendations Regarding the 2016 Point In Time Survey:

Below is a box listing out pros and cons for the different possible methodologies the Maine Continuum of Care can choose to approve for use during the 2016 Point In Time Survey. When considering the various options please consider the following questions, which come from the HUD 2014 Point In Time Count Methodology Guide:

- How large a geographic area does the CoC cover? (page 19)
- Does the CoC have very limited resources relative to the geographic area of the CoC to count and survey all unsheltered people on the night of the count? (page 19)
- Does the CoC believe there might be people experiencing homelessness that enumerators are not likely to identify during an unsheltered count or are there other barriers that could limit the ability of enumerators to conduct interviews during the night of the count?" (page 20)

	Night of Count	Service-Based	Combination Night of and Service-Based
PROs:	-Minimal chance of duplication	-More likely to capture information on those who do not frequent traditional "homeless" services -Can be conducted for up to 7 days after the designated count night	-HUD recommended approach for those CoCs that cover a large geographic location. -Can be conducted for up to 7 days after the designated count night -It provides a more reasonable time frame to reach homeless people in the most rural parts of the state
CONS:	-Enormous geographic area to cover in a very small window of time. -Requires a large # of volunteers to accomplish -More likely to miss those who do not have contact with shelters/services and sleep in unknown locations	-Greater possibility of duplication -You cannot assume that everyone you are encountering is homeless. -Unless it is coupled with a street count, it is likely to miss unsheltered homeless people who do not use any services. -HUD strongly recommends that service-based counts only be used to supplement night of count approaches.	-It takes more time/work to coordinate -Must do a more extensive interview to better avoid duplication of information.

(Please note: all information in this chart comes from the HUD 2014 PIT Count Methodology Guide)

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(Please note: all information in this chart comes from the HUD 2014 PIT Count Methodology Guide)

ME-502 City of Portland Continuum of Care AHAR Summary

Category	2014 AHAR Year 10/1/13-10/1/14	2015 AHAR Year 10/1/14-9/30/15	Change Margin
Emergency Shelter – Families	1034	826	-20.12%
Emergency Shelter – Individuals	2640	2252	-14.70%
Transitional Housing – Families	148	130	-12.16%
Transitional Housing – Individuals	310	261	-15.81%
Permanent Supportive Housing - Families	140	205	46.43%
Permanent Supportive Housing - Individuals	333	395	18.62%

The key finding in this comparison is exciting news. You will note that in all Emergency Shelter and Transitional Housing programs have had reductions in the number of clients and the number of clients served in permanent supportive housing programs has increased. This is great!

This information is composed of aggregate HMIS data from the project types listed above. The report is submitted to the HDX via an xml upload process designed by Bowman Systems. Providers have confirmed to me that their data is correct in HMIS, and therefore those clients included in the xml generated out of ServicePoint.

It is also worth noting that less than one percent of fields had data quality issues in almost all demographic categories. Great work, Portland CoC!