

# 2024 Anchorage Point-In-Time (PIT) Unsheltered Count Survey

## INSTRUCTIONS

This form is to be completed with clients asking where they slept on the night of Monday, January 29, 2024. Unanswered questions will not be interpreted for data entry. Include notes if necessary. Answer all required questions to the best of your ability. To enter the data from this form into the Unsheltered PIT (POINT IN TIME) portal later, use the link found on the ICA Website page: [Alaska PIT/HIC](#)

**All data should be entered by February 8, 2024.**

## INFORMED CONSENT STATEMENT (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 do not want to take the survey, you do not have to answer any questions.
- If you do take the survey, you can stop, you can change your mind, or you can skip questions with no bad consequences.
- Doing the survey or not doing the survey will not 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 do not 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 I will record your answers. It takes about 10 minutes.
- Have you already been interviewed for this year's Point in Time?
  - Yes (If yes, thank them for their time and end the survey)
  - No (Continue asking the survey questions)

## TYPE OF ENCOUNTER

- Interview / Project Homeless Connect Event       Observational (I cannot talk to this person)

## WHERE DID THE ENCOUNTER OCCUR?

- |                                |                                |                                |                                |                                |                                |
|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 99501 | <input type="checkbox"/> 99507 | <input type="checkbox"/> 99511 | <input type="checkbox"/> 99516 | <input type="checkbox"/> 99520 | <input type="checkbox"/> 99524 |
| <input type="checkbox"/> 99502 | <input type="checkbox"/> 99508 | <input type="checkbox"/> 99513 | <input type="checkbox"/> 99517 | <input type="checkbox"/> 99521 | <input type="checkbox"/> 99529 |
| <input type="checkbox"/> 99503 | <input type="checkbox"/> 99509 | <input type="checkbox"/> 99514 | <input type="checkbox"/> 99518 | <input type="checkbox"/> 99522 | <input type="checkbox"/> 99530 |
| <input type="checkbox"/> 99504 | <input type="checkbox"/> 99510 | <input type="checkbox"/> 99515 | <input type="checkbox"/> 99519 | <input type="checkbox"/> 99523 | <input type="checkbox"/> 99599 |

## NAME OF PERSON BEING SURVEYED

First Name	MI	Last Name	Aliases
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## WHERE WERE YOU SLEEPING ON THE NIGHT OF MONDAY, JANUARY 29?

*If the response is anything but a place not meant for habitation, thank the individual for their time and end the survey.*

- |                                                                        |                                                        |                                                       |
|------------------------------------------------------------------------|--------------------------------------------------------|-------------------------------------------------------|
| <input type="checkbox"/> On streets / homeless camp                    | <input type="checkbox"/> Local homeless shelter        | <input type="checkbox"/> Hotel / Motel                |
| <input type="checkbox"/> Abandoned property (not meant for habitation) | <input type="checkbox"/> Friends / Family (doubled-up) | <input type="checkbox"/> Jail / Institutional Setting |
| <input type="checkbox"/> Vehicle / car                                 | <input type="checkbox"/> My apartment / house          | <input type="checkbox"/> Other (specify): _____       |
| <input type="checkbox"/> Warming Shelter                               |                                                        |                                                       |

## ON THE NIGHT OF JANUARY 29, WERE YOU WITH A HOUSEHOLD OR BY YOURSELF?

*If the person is with a household, make sure that you are first talking with the Head of Household.*

- By Myself (Single)
- With Household (Family) If you were with a household, how many people in the household including yourself? Specify: \_\_\_\_\_
- \*If this was a household, complete a separate form with each additional household member.

## AGE CATEGORY

- |                                       |                                  |                                  |                                       |
|---------------------------------------|----------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> Under age 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 | Prefers not to answer / Doesn't know  |

## GENDER

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

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## RACE / ETHNICITY

- |                                                                        |                                                              |                                                               |
|------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> American Indian, Alaska Native, or Indigenous | <input type="checkbox"/> Black, African American, or African | <input type="checkbox"/> White                                |
| <input type="checkbox"/> Asian or Asian American                       | <input type="checkbox"/> Native Hawaiian or Pacific Islander | <input type="checkbox"/> Middle Eastern or North African      |
| <input type="checkbox"/> Hispanic/Latin(o)(a)(x)                       | <input type="checkbox"/> Non-Hispanic/Non-Latin(o)(a)(x)     | <input type="checkbox"/> Prefers not to answer / Doesn't know |

## 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"/> Prefers not to answer / Doesn't know |
|-------------------------------------------|-----------------------------------------|---------------------------------------------------------------|

## NUMBER OF TIMES HAVE YOU BEEN HOMELESS ON THE STREETS OR IN SHELTERS IN THE PAST 3 YEARS?

- |                                                 |                                      |                                          |                                                               |
|-------------------------------------------------|--------------------------------------|------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> This is the first time | <input type="checkbox"/> 2 – 3 times | <input type="checkbox"/> 4 or more times | <input type="checkbox"/> Prefers not to answer / Doesn't know |
|-------------------------------------------------|--------------------------------------|------------------------------------------|---------------------------------------------------------------|

## TOTAL NUMBER OF MONTHS YOU SPENT AT LEAST ONE DAY HOMELESS ON THE STREETS OR IN SHELTERS IN THE PAST 3 YEARS?

- |                                               |                                            |                                                               |
|-----------------------------------------------|--------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Fewer than 12 months | <input type="checkbox"/> 12 months or more | <input type="checkbox"/> Prefers not to answer / Doesn't know |
|-----------------------------------------------|--------------------------------------------|---------------------------------------------------------------|

## DO YOU HAVE A DISABILITY? MARK ALL THAT APPLY.

- |                                                   |                                            |                                                               |
|---------------------------------------------------|--------------------------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> None                     | <input type="checkbox"/> Developmental     | <input type="checkbox"/> Mental Health Disorder               |
| <input type="checkbox"/> Alcohol Use Disorder     | <input type="checkbox"/> Drug Use Disorder | <input type="checkbox"/> Physical Disability                  |
| <input type="checkbox"/> Chronic Health Condition | <input type="checkbox"/> HIV / AIDS        | <input type="checkbox"/> Prefers not to answer / Doesn't know |

## ARE YOU A SURVIVOR OR HAVE YOU BEEN A VICTIM OF DOMESTIC VIOLENCE?

- |                                                                                                         |                              |                             |                                                               |
|---------------------------------------------------------------------------------------------------------|------------------------------|-----------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Yes If yes, are/were you fleeing that DV situation on the night of January 29? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Prefers not to answer / Doesn't know |
| <input type="checkbox"/> No                                                                             |                              |                             |                                                               |
| <input type="checkbox"/> Prefers not to answer / Doesn't know                                           |                              |                             |                                                               |

## HAVE YOU EVER SERVED IN THE UNITED STATES MILITARY?

- |                                                                                                                                                                                                                                                            |                             |                                                               |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------|---------------------------------------------------------------|
| <input type="checkbox"/> Yes (If yes, fill in Veteran information below.)                                                                                                                                                                                  | <input type="checkbox"/> No | <input type="checkbox"/> Prefers not to answer / Doesn't know |
| Veteran Social Security Number: _____ - _____ - _____                                                                                                                                                                                                      |                             | <input type="checkbox"/> Prefers not to answer / Doesn't know |
| Veteran Date of Birth: _____ / _____ / _____                                                                                                                                                                                                               |                             | <input type="checkbox"/> Prefers not to answer / Doesn't know |
| Branch of Service: <input type="checkbox"/> Air Force <input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Marine Corps <input type="checkbox"/> Coast Guard <input type="checkbox"/> Prefers not to answer / Doesn't know |                             |                                                               |
| National Guard / Reserve? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Prefers not to answer / Doesn't know                                                                                                           |                             |                                                               |
| Contact Info (Optional): Phone: _____                                                                                                                                                                                                                      | Email: _____                | Other: _____                                                  |

## WOULD YOU LIKE TO SHARE THE REASONS/FACTORS YOU FEEL CONTRIBUTED TO YOUR HOMELESSNESS?

*If the person is in the household, make sure that you are first talking with the Head of Household.*

- |                                                               |                                                           |                                                         |
|---------------------------------------------------------------|-----------------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Unable to Pay Rent/Mortgage          | <input type="checkbox"/> Asked to leave or evicted        | <input type="checkbox"/> Lost a job could not find work |
| <input type="checkbox"/> Relationship problems/family breakup | <input type="checkbox"/> Alcohol/Substance abuse problems | <input type="checkbox"/> Other (specify): _____         |

## ADDITIONAL NOTES:

If you complete the Veteran's Supplemental Section, this entire survey will be shared with the Veteran's Administration. If you and/or your household are willing to participate, please sign below. Thank you for your help.

Client Signature: \_\_\_\_\_

Surveyor Printed Name: \_\_\_\_\_

Surveyor Organization Affiliation (if any): \_\_\_\_\_