

**Northwest Arkansas Annual Point in Time Count – 2023**

Location (agency/description/address/intersection): \_\_\_\_\_

City: \_\_\_\_\_ County (circle one): Benton Washington Carroll Madison

Interviewer: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

Hello, my name is \_\_\_\_\_ and I'm a volunteer for the NWA Continuum of Care. We are conducting a survey to learn more about people experiencing homelessness in this area so we can provide programs and services to them. Your participation is voluntary, we will not record your name, and we will never identify you as an individual. I need to read each question all the way through. We do this even when questions seem straight forward to avoid making assumptions or mistakes. Can I have about 10 minutes of your time?

☐ YES (Go to #1) ☐ NO (Thank respondent, offer contact form, then COMPLETE OBSERVATION FORM)

|                                                                                                                                                                                                                                                                                                                                              |                                                                                   |                                                          |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------|----------------------------------------------------------|
| 1. Have you completed this survey earlier today or last night?                                                                                                                                                                                                                                                                               |                                                                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Including yourself, how many adults and children are there in your household, who slept in the same location as you last night?<br>_____ Adults (Age 18 and older) _____ Children (Age 17 and younger)                                                                                                                                    |                                                                                   |                                                          |
| 3. Where did you sleep last night?"<br><br><b>(Do not read categories, select only one category.)</b><br><br><b>If respondent answers house, apartment, or hotel/motel paid by self or family, they are not considered homeless by HUD. Say, "Thank you, that is the only question I have right now."</b><br><br><b>Otherwise, go to #4.</b> | <input type="checkbox"/> House or apartment (yours or someone else's)             |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Hotel/motel (paid by self or family)                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Street or sidewalk                                       |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Park                                                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Under bridge/overpass                                    |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Woods or outdoor encampment                              |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Bus or train station, airport                            |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Motel/Hotel (paid by agency) (please list agency): _____ |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Jail, hospital, or treatment program                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Transition housing (please list program): _____          |                                                          |
| <input type="checkbox"/> Abandoned building                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                          |
| <input type="checkbox"/> Emergency Shelter (please list program): _____                                                                                                                                                                                                                                                                      |                                                                                   |                                                          |
| <input type="checkbox"/> Vehicle (car, van, truck, bus or RV without utility hook-ups)                                                                                                                                                                                                                                                       |                                                                                   |                                                          |
| <input type="checkbox"/> Other (please specify): _____                                                                                                                                                                                                                                                                                       |                                                                                   |                                                          |
| 4. How long have you been staying/sleeping in this situation?<br>_____ Days _____ Weeks _____ Months _____ Years<br><b>If unsure, was it less than 90-days?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No                                                                                                                     |                                                                                   |                                                          |
| 5. Where did you stay before that?"<br><br><b>(Do not read categories, select only one category.)</b>                                                                                                                                                                                                                                        | <input type="checkbox"/> House or apartment (yours or someone else's)             |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Hotel/motel (paid by self or family)                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Street or sidewalk                                       |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Park                                                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Under bridge/overpass                                    |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Woods or outdoor encampment                              |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Bus or train station, airport                            |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Motel/Hotel (paid by agency) (please list agency): _____ |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Jail, hospital, or treatment program                     |                                                          |
|                                                                                                                                                                                                                                                                                                                                              | <input type="checkbox"/> Transition housing (please list program): _____          |                                                          |
| <input type="checkbox"/> Abandoned building                                                                                                                                                                                                                                                                                                  |                                                                                   |                                                          |
| <input type="checkbox"/> Emergency Shelter (please list program): _____                                                                                                                                                                                                                                                                      |                                                                                   |                                                          |
| <input type="checkbox"/> Vehicle (car, van, truck, bus or RV without utility hook-ups)                                                                                                                                                                                                                                                       |                                                                                   |                                                          |
| <input type="checkbox"/> Other (please specify): _____                                                                                                                                                                                                                                                                                       |                                                                                   |                                                          |
| 6. How long have you been staying/sleeping in that situation?<br>_____ Days _____ Weeks _____ Months _____ Years                                                                                                                                                                                                                             |                                                                                   |                                                          |

**For Questions 7 through 37, please do the following:**

- Ask all questions for the person you are interviewing (adult or youth on own)
- Ask all questions for any additional adults in the household or if all household members are youth on own.
  - Note: A youth under age 18 without an adult is the de facto head of household. Thus, we ask all items.
- Ask Questions 7 through 11 for any additional child or youth in an adult-headed household.
- For additional members, please ask them directly if present and able. Otherwise, ask the person interviewing.
- Please use an additional survey and attach to this if more than 2 additional members.

|                                                    | Person You Are Interviewing                                                                                                                                                                                                                                                                          | Person 2                                                                                                                                                                                                                                                                                             | Person 3                                                                                                                                                                                                                                                                                             |
|----------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| How are these people related to you?               |                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Child<br><input type="checkbox"/> Married or unmarried partner<br><input type="checkbox"/> Other Family<br><input type="checkbox"/> Other, _____                                                                                                                            | <input type="checkbox"/> Child<br><input type="checkbox"/> Married or unmarried partner<br><input type="checkbox"/> Other Family<br><input type="checkbox"/> Other, _____                                                                                                                            |
| 7. What are your/their initials?                   |                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                      |
| 8. How old are you/they?                           |                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                      |
| 8a (If hesitant, ask) Are you/they...?             | <input type="checkbox"/> Under 18<br><input type="checkbox"/> 18-24<br><input type="checkbox"/> 25-34<br><input type="checkbox"/> 35-44<br><input type="checkbox"/> 45-54<br><input type="checkbox"/> 55-64<br><input type="checkbox"/> 65 and older<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Under 18<br><input type="checkbox"/> 18-24<br><input type="checkbox"/> 25-34<br><input type="checkbox"/> 35-44<br><input type="checkbox"/> 45-54<br><input type="checkbox"/> 55-64<br><input type="checkbox"/> 65 and older<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Under 18<br><input type="checkbox"/> 18-24<br><input type="checkbox"/> 25-34<br><input type="checkbox"/> 35-44<br><input type="checkbox"/> 45-54<br><input type="checkbox"/> 55-64<br><input type="checkbox"/> 65 and older<br><input type="checkbox"/> Not sure or refused |
| 9. Are you/they Hispanic or Latino?                | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                          |
| 10. What is your race?<br>(Select all that apply.) | <input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White<br><input type="checkbox"/> Not sure or refused                     | <input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White<br><input type="checkbox"/> Not sure or refused                     | <input type="checkbox"/> American Indian or Alaska Native<br><input type="checkbox"/> Asian<br><input type="checkbox"/> Black or African American<br><input type="checkbox"/> Pacific Islander<br><input type="checkbox"/> White<br><input type="checkbox"/> Not sure or refused                     |
| 11. What is your gender?                           | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Transgender<br><input type="checkbox"/> A gender not singularly F or M<br><input type="checkbox"/> Questioning<br><input type="checkbox"/> Not sure or refused                                          | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Transgender<br><input type="checkbox"/> A gender not singularly F or M<br><input type="checkbox"/> Questioning<br><input type="checkbox"/> Not sure or refused                                          | <input type="checkbox"/> Male<br><input type="checkbox"/> Female<br><input type="checkbox"/> Transgender<br><input type="checkbox"/> A gender not singularly F or M<br><input type="checkbox"/> Questioning<br><input type="checkbox"/> Not sure or refused                                          |

|                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 12. How long have you been in this episode of homelessness?<br><br><b>(If unclear, prompt for 1-year or longer.)</b> | <input type="checkbox"/> 1 week or less<br><input type="checkbox"/> 1 Week to 1 month<br><input type="checkbox"/> 1-3 months<br><input type="checkbox"/> 3 months to 1 year<br><input type="checkbox"/> 1 year or longer<br><input type="checkbox"/> Not sure or refused                                                                                       | <input type="checkbox"/> 1 week or less<br><input type="checkbox"/> 1 Week to 1 month<br><input type="checkbox"/> 1-3 months<br><input type="checkbox"/> 3 months to 1 year<br><input type="checkbox"/> 1 year or longer<br><input type="checkbox"/> Not sure or refused                                                                                       | <input type="checkbox"/> 1 week or less<br><input type="checkbox"/> 1 Week to 1 month<br><input type="checkbox"/> 1-3 months<br><input type="checkbox"/> 3 months to 1 year<br><input type="checkbox"/> 1 year or longer<br><input type="checkbox"/> Not sure or refused                                                                                       |
| 13. In the past 3 years, how many TIMES have you been homeless<br><b>(including this time)</b>                       | <input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times<br><input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 or more times<br><input type="checkbox"/> Not sure or refused                                                                                                                                                            | <input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times<br><input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 or more times<br><input type="checkbox"/> Not sure or refused                                                                                                                                                            | <input type="checkbox"/> 1 time<br><input type="checkbox"/> 2 times<br><input type="checkbox"/> 3 times<br><input type="checkbox"/> 4 or more times<br><input type="checkbox"/> Not sure or refused                                                                                                                                                            |
| 14. In the past 3 years, how many MONTHS have you been homeless<br><b>(including this time)</b>                      |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
| 14a. If unclear, ask if 12 months or more.                                                                           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                    |
| 15. When you last considered yourself to be stably housed, where did you live?                                       | <input type="checkbox"/> Benton County<br><input type="checkbox"/> Carroll County<br><input type="checkbox"/> Madison County<br><input type="checkbox"/> Washington County<br><input type="checkbox"/> Elsewhere in AR<br><input type="checkbox"/> Elsewhere in US<br><input type="checkbox"/> Another country<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Benton County<br><input type="checkbox"/> Carroll County<br><input type="checkbox"/> Madison County<br><input type="checkbox"/> Washington County<br><input type="checkbox"/> Elsewhere in AR<br><input type="checkbox"/> Elsewhere in US<br><input type="checkbox"/> Another country<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Benton County<br><input type="checkbox"/> Carroll County<br><input type="checkbox"/> Madison County<br><input type="checkbox"/> Washington County<br><input type="checkbox"/> Elsewhere in AR<br><input type="checkbox"/> Elsewhere in US<br><input type="checkbox"/> Another country<br><input type="checkbox"/> Not sure or refused |
| 16. If last stable was one of the 4 NWA counties, ask for city or town.                                              |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
| 17. What is your sexual orientation?                                                                                 | <input type="checkbox"/> Straight or heterosexual<br><input type="checkbox"/> Gay or lesbian<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> Not sure or refused                                                                                                                                      | <input type="checkbox"/> Straight or heterosexual<br><input type="checkbox"/> Gay or lesbian<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> Not sure or refused                                                                                                                                      | <input type="checkbox"/> Straight or heterosexual<br><input type="checkbox"/> Gay or lesbian<br><input type="checkbox"/> Bisexual<br><input type="checkbox"/> Other _____<br><input type="checkbox"/> Not sure or refused                                                                                                                                      |
| 18. Have you ever served on Active Duty in the US Military                                                           | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(Skip to #24)</b><br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                               | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(Skip to #24)</b><br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                               | <input type="checkbox"/> Yes<br><input type="checkbox"/> No <b>(Skip to #24)</b><br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                               |
| 19. What year did you enter military service?                                                                        |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
| 20. What year did you leave military service?                                                                        |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
| 21. Which branch did you serve in the longest?                                                                       |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |                                                                                                                                                                                                                                                                                                                                                                |
| 22. What is your discharge status?                                                                                   | <input type="checkbox"/> Honorable<br><input type="checkbox"/> General<br><input type="checkbox"/> Other than honorable<br><input type="checkbox"/> Dishonorable<br><input type="checkbox"/> Bad conduct<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused                                                              | <input type="checkbox"/> Honorable<br><input type="checkbox"/> General<br><input type="checkbox"/> Other than honorable<br><input type="checkbox"/> Dishonorable<br><input type="checkbox"/> Bad conduct<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused                                                              | <input type="checkbox"/> Honorable<br><input type="checkbox"/> General<br><input type="checkbox"/> Other than honorable<br><input type="checkbox"/> Dishonorable<br><input type="checkbox"/> Bad conduct<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused                                                              |

|                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                                             |                                                                                                             |                                                                                                             |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------|
| 23. Have you ever received health care benefits from a VA medical center?                                                                                                                                                                                                                                                                                                                                                                                                                      | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| <b>Prompt: The next set of questions asks about sensitive topics and may be upsetting. We want to keep your information private. I can read the questions like normal, or, if you prefer, you may read each question silently and point to the answers that apply to you. Otherwise, I can read them out loud and you can respond with the numbers or a quick yes or no. You don't have to answer any questions you don't want to, and I'll simply move on. How would you like to proceed?</b> |                                                                                                             |                                                                                                             |                                                                                                             |
| 24. Do you receive federal disability benefits such as SSI, SSDI, or Veteran's Disability?<br>(This does not include pension or retirement benefits.)                                                                                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| 25. Do you drink alcoholic beverages or use drugs (illegal or prescription for non-medical reasons) in a way that creates problems for you?                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| 26. Do you have a psychiatric or emotional disability, such as depression, PTSD, bipolar, or schizophrenia?                                                                                                                                                                                                                                                                                                                                                                                    | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| 27. Do you have a chronic health condition or a physical disability that significantly limits one or more basic physical activities such as walking, climbing stairs, seeing, lifting, or carrying?                                                                                                                                                                                                                                                                                            | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| 28. Do you have a developmental disability, such as autism, an intellectual disability, cerebral palsy, or a brain disorder or injury?                                                                                                                                                                                                                                                                                                                                                         | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |
| 29. Do you have AIDS or an HIV related illness?<br>(As needed, clarify that HIV related illness would be based on 1) having HIV and 2) having one of several conditions due to a weakened immune system)                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused |

|                                                                                                                                 |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |
|---------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 30. Is your <i>current</i> homelessness because you are fleeing domestic violence, dating violence, sexual assault or stalking? | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          |
| 31. Do you have a felony conviction or guilty plea on your record?                                                              | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          |
| 32. Do you have an eviction on record?                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          |
| 33. Were/are you in the foster care or child welfare system during childhood?                                                   | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused                                                                                                                                                                                                                                                                          |
| 34. Which single factor do you feel contributes most to your current homelessness?                                              |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |
| 35. Has any aspect of your identity made it harder to get help from the homeless response system in NWA?                        | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused<br><br><b>(If no, skip to end of interview.)</b>                                                                                                                                                                                                                         | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused<br><br><b>(If no, skip to end of interview.)</b>                                                                                                                                                                                                                         | <input type="checkbox"/> Yes<br><input type="checkbox"/> No<br><input type="checkbox"/> Not sure or refused<br><br><b>(If no, skip to end of interview.)</b>                                                                                                                                                                                                                         |
| 36. If yes, which identity or identities <b>(pick all that apply)</b> ?                                                         | <input type="checkbox"/> Race or ethnicity<br><input type="checkbox"/> Gender<br><input type="checkbox"/> Age<br><input type="checkbox"/> Disability<br><input type="checkbox"/> Sexual orientation<br><input type="checkbox"/> Gender identity<br><input type="checkbox"/> Criminal record<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Race or ethnicity<br><input type="checkbox"/> Gender<br><input type="checkbox"/> Age<br><input type="checkbox"/> Disability<br><input type="checkbox"/> Sexual orientation<br><input type="checkbox"/> Gender identity<br><input type="checkbox"/> Criminal record<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused | <input type="checkbox"/> Race or ethnicity<br><input type="checkbox"/> Gender<br><input type="checkbox"/> Age<br><input type="checkbox"/> Disability<br><input type="checkbox"/> Sexual orientation<br><input type="checkbox"/> Gender identity<br><input type="checkbox"/> Criminal record<br><input type="checkbox"/> Other: _____<br><input type="checkbox"/> Not sure or refused |
| 37. Finally, would you like to share an example or comment related to how your identity has affected access to services?        |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                                                                                                                                                                                                      |

**Those are all the questions I have for you. We realize that some of the topics covered are personal and can be difficult to talk about. We appreciate your willingness to participate. Thank you for taking the survey!**

|                                                                                    |  |
|------------------------------------------------------------------------------------|--|
| As needed, please provide any notes that will help us in assessing this interview. |  |
|------------------------------------------------------------------------------------|--|