

Count Volunteer Name: _____

Email Address: _____

Count Volunteer Phone #: _____

Count Team #: _____

No.	Location	Survey Type	Client Identifiers (to avoid duplication)		Gender	Ethnicity	Race	Homeless History				Veteran	Health and Behavioral Health Issues X if Yes								Entered In App?	Additional Notes				
			Name or Initials	Date of Birth or Estimated Age				M= Male Trans M:F Nonconforming	Hispanic or Latino? Yes/No	A=Indian B=Black W=White	First Time Homeless? (Yes/No)		How Long Homeless this Time (Yrs / Months)	How Many Times Homeless past 3 yrs?	How Long Homeless in Total? (Yrs / Months)	Ever Served in US Military? / Guard: active duty	Substance Abuse A=Alcohol D=Drugs B=Both	If Substance abuse, is long term disability that impairs living?	Chronic Health Condition	If chronic health, is long term disability that impairs living?			Mental Health Condition (includes PTSD)	If mental health, is long term disability that impairs living?	Physical Disability	If physical disability, is long term disability that impairs living?
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