Tri-County Head Start/Early Head Start

Living Situation Survey

Child _____ DOB _____

Parent/Guardian _____

Each family who qualifies for Head Start services due to being homeless must be assisted by assessing their current living situation. Use this form as needed.

What phone number should we use to reach you or leave a message for you?

Phone Number 1_____ Phone Number 2_____

Contact Person's Name_____

Where do you want us to send you mail? _____

History

1. Where were you living right before this move? _____
   _____
2. How long did you live there? _____
3. How did you lose your housing?
   - ☐ Eviction
   - ☐ Destruction/Damage
   - ☐ Condemned/Uninhabitable
   - ☐ Lease/Rental Agreement Violation
   - ☐ Foreclosure
   - ☐ Economic Hardship
   - ☐ Divorce/Family Break Up
   - ☐ Other: _____

4. Contributing factor(s) to homelessness (check all that apply):
   - ☐ Addiction/Substance Abuse
   - ☐ Moved to seek work.
   - ☐ Domestic Violence
   - ☐ Illness
   - ☐ Jail/Incarceration
   - ☐ Physical/Mental Disability
   - ☐ Unable to pay rent/mortgage.
   - ☐ Unemployment
   - ☐ Loss of TANF
   - ☐ Other: _____

Current Situation

1. Where are you currently living?
   - ☐ Emergency Shelter
   - ☐ Domestic Violence Shelter
   - ☐ On the Street
   - ☐ Friend/Acquaintance
   - ☐ Motel/Hotel/Campground
   - ☐ Transitional Housing
   - ☐ Car, Camper, Etc.
   - ☐ Relative
   - ☐ Shared Housing
   - ☐ Other: _____

2. Is your current living situation temporary or long term? _____
3. How long will you be at your current location?_____
4. Why are you staying in your current location?_____
5. Where would you go if you could not stay where you are currently living?_____
   _____
6. Could your friends/relatives ask you to leave if they wanted to?_____
7. Do you stay in the same place every night?_____

Other Needs

1. Are you aware of the services and rights available to you and your child(ren) because you lost your home?
2. Do you have any current personal needs?
   - ☐ Medical/Dental Care
   - ☐ Eyeglasses
   - ☐ Mental Health Services
   - ☐ Clothing
   - ☐ Personal Care Items
   - ☐ Food
   - ☐ Household Goods
   - ☐ Other: _____

Future Plans

1. Are you looking for permanent housing? _____
2. If so, where? _____
3. Are you looking for another place to live (this could be another temporary living situation)? _____
4. What prevents you from getting into permanent housing?_____
   _____
5. What efforts have you made to address those barriers?_____
   _____
6. What school will our child attend when they leave Head Start?_____
   _____
7. How can Head Start assist you?_____
   _____
   _____

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How was this information gathered?

- ☐ In-Person
- ☐ Over the phone

Family has been provided with:

- ☐ Name of Homeless Liaison in the Family's School District
- ☐ Copy of the right under the McKinney Vento Act
- ☐ Community Resource Directory
- ☐ External Referral(s), if applicable

Parent/Guardian Signature	Date
Staff Signature	Date