

7. Where was your last permanent address before becoming homeless?

Town: _____ County: _____

State: _____ Country: _____

8. What was your residence prior to your current living situation? (Check ONE only)

<input type="checkbox"/>	Emergency Shelter, or Emergency Hotel Voucher
<input type="checkbox"/>	Safe Haven
<input type="checkbox"/>	Hotel/Motel Paid for Without Voucher
<input type="checkbox"/>	Transitional Housing for Homeless Persons
<input type="checkbox"/>	Permanent Supportive Housing Program
<input type="checkbox"/>	Medical Hospital (emergency room, acute care)
<input type="checkbox"/>	Psychiatric Hospital or treatment facility
<input type="checkbox"/>	Substance Abuse Treatment Facility/Detox
<input type="checkbox"/>	Foster Care
<input type="checkbox"/>	Jail, Prison, or Juvenile Detention Facility
<input type="checkbox"/>	Staying Temporarily with Family or Friends
<input type="checkbox"/>	Place Not Meant For Human Habitation (On the Street, Bus, Car, Airport, Abandoned Building)
<input type="checkbox"/>	Apartment paid for with Temporary Rental Assistance from the Board of Social Services
<input type="checkbox"/>	Rental Housing with Subsidy
<input type="checkbox"/>	Rental Housing without Subsidy
<input type="checkbox"/>	Owned Housing with Subsidy
<input type="checkbox"/>	Owned Housing without Subsidy
<input type="checkbox"/>	Other: _____

9. Which of the following do you, or anyone in your household receive? (Check ALL that apply)

<i>Sources of Income</i>	<i>Non-Cash Benefits</i>		
<input type="checkbox"/>	SSI	<input type="checkbox"/>	Food stamps/SNAP
<input type="checkbox"/>	SSDI	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	TANF	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	General /Public Assistance/Welfare	<input type="checkbox"/>	State Children's Health Insurance/FamilyCare
<input type="checkbox"/>	Unemployment	<input type="checkbox"/>	VA Benefits
<input type="checkbox"/>	Private Disability Insurance	<input type="checkbox"/>	WIC/Special Nutrition Program for Women, Infants, and Children
<input type="checkbox"/>	Work Income/Wage	<input type="checkbox"/>	TANF Child Care
<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/>	TANF Transportation
<input type="checkbox"/>	Alimony	<input type="checkbox"/>	Other TANF-Funded Service
<input type="checkbox"/>	Child Support	<input type="checkbox"/>	Temporary Rental Assistance
<input type="checkbox"/>	Social Security	<input type="checkbox"/>	Section 8/Public Housing/Ongoing Rental Assistance
<input type="checkbox"/>	Veteran's Disability	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Pension From Former Job	<input type="checkbox"/>	Receiving NO Government Benefits
<input type="checkbox"/>	Veteran's Pension		
<input type="checkbox"/>	Other: _____		
<input type="checkbox"/>	No Source of Income		

10. What is your total monthly household income?

\$ _____

11. Would you, or anyone in your household, like to receive any of the following services? (Check ALL that apply)

<input type="checkbox"/>	Emergency Shelter
<input type="checkbox"/>	Housing
<input type="checkbox"/>	Substance Abuse Services
<input type="checkbox"/>	Mental Health Care
<input type="checkbox"/>	Medical Care (disability)
<input type="checkbox"/>	Medical Care (routine healthcare)
<input type="checkbox"/>	Dental Care
<input type="checkbox"/>	HIV/AIDS Services
<input type="checkbox"/>	Financial Assistance for Utilities
<input type="checkbox"/>	Financial Assistance for Housing
<input type="checkbox"/>	Financial Assistance for Moving Expenses
<input type="checkbox"/>	Emergency Food or Meal Assistance
<input type="checkbox"/>	Domestic Violence Services
<input type="checkbox"/>	Legal Services
<input type="checkbox"/>	Immigration Services
<input type="checkbox"/>	Assistance Obtaining ID
<input type="checkbox"/>	Child Care
<input type="checkbox"/>	Educational Training
<input type="checkbox"/>	Employment Assistance
<input type="checkbox"/>	Transportation Services
<input type="checkbox"/>	Veterans Services
<input type="checkbox"/>	Family Reunification
<input type="checkbox"/>	Other: _____

12. What was the primary factor that contributed to or caused your current living situation? (Check ONE only)

<input type="checkbox"/>	Loss or Reduction of Benefits
<input type="checkbox"/>	Loss or Reduction of Job Income
<input type="checkbox"/>	Eviction or at Risk of Eviction
<input type="checkbox"/>	Relocation
<input type="checkbox"/>	Released From Prison/Jail
<input type="checkbox"/>	Released From Hospital
<input type="checkbox"/>	Released from Psychiatric Facility
<input type="checkbox"/>	Illness
<input type="checkbox"/>	Injury
<input type="checkbox"/>	Domestic Violence
<input type="checkbox"/>	Asked To Leave Shared Residence
<input type="checkbox"/>	Drug/Alcohol Abuse
<input type="checkbox"/>	Natural Disaster
<input type="checkbox"/>	Foreclosure of Rented or Owned Property
<input type="checkbox"/>	Other: _____

Thank you for participating in NJ Counts 2014!