

Kitsap Point In Time Count / WINTER – Use Form Jan 27 – 30, 2026

UNSHELTERED/LIVING WITH FAMILY OR FRIENDS

Return forms by 2/3/26 to:

Cory Derenburger
Housing & Homelessness Division, Kitsap County
345 6th Street, Suite 400, Bremerton WA 98337

- If individual/household is staying at an emergency shelter, do not use this form, the shelter will collect this information.

A. Interview Location: _____		Project Connect	
City/Town where household sleeping: _____		<input type="checkbox"/> Silverdale <input type="checkbox"/> Bremerton <input type="checkbox"/> Port Orchard	
B. *Where did/will you sleep the night of Thursday, Jan 29th? (choose one, applies to entire household)			
<input type="radio"/> Out of Doors (street, tent, etc.) <input type="radio"/> Vehicle <input type="radio"/> Abandoned Building <input type="radio"/> RV/Boat Lacking Any of the Following Amenities Drinking water, restroom, heat, ability to cook hot food, ability to bathe		<input type="radio"/> Temp. Living w/ Family or Friends + _____ (how long) <input type="radio"/> Hospital/Detox/Other facility + _____ (which one) <input type="radio"/> Jail + _____ (which jail/prison) <input type="radio"/> Shelter + _____ (which shelter) †Not considered unsheltered for PIT by HUD; Optional	
C. Housing Questions			
1. Has any adult or minor head of household been <u>continuously</u> without housing for a year or more?		<input type="checkbox"/> No (go to 2a) <input type="checkbox"/> Yes (skip to 3)	
2.a. Has any adult or minor head of household been without housing 4 or more times in the last 3 years?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
2.b. Do these times without housing, added together, amount to a year or more?		<input type="checkbox"/> No <input type="checkbox"/> Yes	
3. Last known permanent City, State _____		Zip _____	
D. Household Information			
Household Type <input type="checkbox"/> Household without children <input type="checkbox"/> Household with children <input type="checkbox"/> Household with only children (under 18)			
Fleeing Domestic Violence <input type="checkbox"/> No <input type="checkbox"/> Yes*		<input type="checkbox"/> No <input type="checkbox"/> Yes*	
<input type="checkbox"/> No <input type="checkbox"/> Yes*		<input type="checkbox"/> No <input type="checkbox"/> Yes*	
*If any household member is fleeing domestic violence, DO NOT COLLECT name, date of birth, or race/ethnicity, and do not sign this form. DO collect age.			
First & Last Name _____		_____	
Relationship to Head of Household (Self) _____		_____	
Date of Birth or Age _____		_____	
Race and Ethnicity (select all that apply) <input type="checkbox"/> American Indian/Alaska Native/Indigenous <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Black/African American/African <input type="checkbox"/> Hispanic/Latina/o <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Prefers Not to Answer		<input type="checkbox"/> American Indian/Alaska Native/Indigenous <input type="checkbox"/> Asian/Asian American <input type="checkbox"/> Black/African American/African <input type="checkbox"/> Hispanic/Latina/o <input type="checkbox"/> Middle Eastern/North African <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Doesn't Know <input type="checkbox"/> Prefers Not to Answer	
Disabling Conditions/Barriers (select all that apply) <input type="checkbox"/> Physical Disability (permanent) <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Mental Health Disorder (substantial and long-term) <input type="checkbox"/> Substance Use Disorder (substantial and long-term)		<input type="checkbox"/> Physical Disability (permanent) <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> Mental Health Disorder (substantial and long-term) <input type="checkbox"/> Substance Use Disorder (substantial and long-term)	
Veteran (ever active duty in US military) <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> No <input type="checkbox"/> Yes	
E. Review Client Release of Information and Informed Consent Form on back		If actively fleeing domestic violence, sexual assault, or stalking DO NOT SIGN	
		Minimum required fields, survey cannot be entered if missing	

Thank you for helping us improve services to persons with unstable housing

TURN OVER – MORE ON BACK

F. Circumstances leading to your housing status (check all that apply)		<input type="checkbox"/> Prefers not to answer <input type="checkbox"/> Doesn't Know	
Housing & Economic	System & Legal	Health Issues	Family Conflict
<input type="checkbox"/> Lack of job training/unable to work <input type="checkbox"/> Lack of childcare <input type="checkbox"/> Job Loss/unemployment <input type="checkbox"/> Eviction/Loss of housing <input type="checkbox"/> Housing affordability	<input type="checkbox"/> Discharge from hospital/other medical facility <input type="checkbox"/> Discharge from criminal/juvenile justice system <input type="checkbox"/> Aged out of foster care <input type="checkbox"/> Medical costs	<input type="checkbox"/> Illness <input type="checkbox"/> Mental Illness <input type="checkbox"/> Physical health/disability <input type="checkbox"/> Alcohol/substance abuse	<input type="checkbox"/> Domestic Violence <input type="checkbox"/> Guardian mental health/substance abuse <input type="checkbox"/> Family Rejection/Kicked out <input type="checkbox"/> Abuse/Neglect

G. Source(s) of Household Income and Benefits (check all that apply)		<input type="checkbox"/> Prefers not to answer <input type="checkbox"/> Doesn't Know	
Public Assistance/Benefits		Employment	Other
<input type="checkbox"/> TANF <input type="checkbox"/> SSI/SSDI <input type="checkbox"/> Temporary Disability/ABD/HEN	<input type="checkbox"/> VA <input type="checkbox"/> Unemployment <input type="checkbox"/> Medicare/Medicaid/WA Apple Health	<input type="checkbox"/> Part time <input type="checkbox"/> Full time <input type="checkbox"/> Farm/seasonal <input type="checkbox"/> Under the table/informal	<input type="checkbox"/> None <input type="checkbox"/> Panhandling <input type="checkbox"/> Relative/friends

Kitsap Client Release of Information and Informed Consent Form

Washington State Homeless Management Information System (HMIS) and Kitsap HMIS Collaborative Agencies

IMPORTANT: Do not enter personally identifying information into HMIS for clients who are: 1) in DV agencies or; 2) currently fleeing or in danger from a domestic violence, dating violence, sexual assault or stalking situation; 3) are being served in a program that requires disclosure of HIV/AIDS status (i.e.; HOPWA); or 4) under 13 with no parent or guardian available to consent to enter the minor's information in HMIS.

If this applies to you, STOP- Do not sign this form.

This agency participates in the Washington State Homeless Management Information System (HMIS) by collecting information, over time, about the characteristics and service needs of people facing homelessness. RCW 43.185C.180 and RCW 43.185C.030

- To provide the most effective services in moving people from homelessness to permanent housing, we need an accurate count of all people experiencing homelessness in Washington State. In order to insure that clients are not counted twice, we need to collect four pieces of personally identifying information. Specifically, we collect: **name, birth date, and race/ethnicity**. You may also choose to provide your social security number. However, signing this form does not require you to do so. Your information will be stored in our database for 7 years after the last date of service. If you have questions about collection of data or your rights regarding your personally identifying information, contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov
- We use strict security policies designed to protect your privacy. Our computer system is highly secure and uses up-to-date protection features such as data encryption, passwords, and two-factor authentication required for each system user. There is a small risk of a security breach, and someone might obtain and use your information inappropriately. If you ever suspect the data in HMIS has been misused, immediately contact the HMIS System Administrator at: (360) 688-4534 or HMIS@commerce.wa.gov
- The data you provide may be combined with data from the Washington State Department of Social and Health Services (DSHS) and Education Research and Data Center for the purpose of further analysis. Your name and other identifying information will not be included in any reports or publications. Only a limited number of staff members, who have signed confidentiality agreements, will be able to see this information. Your information will not be used to determine eligibility for DSHS programs. Washington State HMIS system administrators have full access to all information in HMIS. This includes the Department of Commerce staff, designated HMIS system administrators, and the software vendor.
- By signing this form, you acknowledge and allow Department of Commerce staff to obtain additional records of information from other state agencies with which there is a data sharing agreement (DSA) on file between Commerce and the other agency. Our DSA guides data transfer and storage security protocols. If DSAs are in place, Commerce is authorized by you to obtain, add to HMIS, and use for evaluation purposes any other data you have provided to other Washington state agencies.
- Your decision to participate in the HMIS will not affect the quality or quantity of services you are eligible to receive from this agency, and will not be used to deny outreach, assistance, shelter or housing. However, if you do choose to participate, services in the region may improve if we have accurate information about homeless individuals and the services they need. Furthermore, some funders MAY require that you consent to provide your personally identifying information in HMIS in order for you to receive services from that funding source.

I understand the above statements and consent to the inclusion of personally identifying information in HMIS about me and any dependents listed below, and authorize information collected to be shared with partner agencies, both state agencies and organizations that participate in the Kitsap HMIS Collaborative. I understand that my personally identifying information will not be made public and will only be used with strict confidentiality. I also understand that I may withdraw my consent at any time by filing a 'Client Revocation of Consent' form with this agency. I understand that I may obtain a copy of my signed consent form from this Agency (including forms signed electronically).

Dependent children under 18 in household, if any (Please print first and last names):

(Client Signature (Parent/Guardian))

Client Name (Print clearly)

Client refused consent _____ (Agency Staff Initials)

Date

Agency Staff Name (Print clearly)

Initials

HMIS Unique Identifier (optional) _____