



advance to zero

local communities
ending homelessness

VI-SPDAT

Prescreen for Young People

Vulnerability Index
Service Prioritization Decision Assistance Tool





The tool, based on people’s disclosed information, assists in prioritising the most vulnerable and to rapidly resolve crisis. This tool is further used to provide appropriate housing, healthcare and community services to individuals and families according to their current circumstances.

Organisations also use the collective, de-identified data to advocate for the change and resources needed to end homelessness in our communities, based on the needs of the people who experience homelessness and housing stress in the community



Advance to Zero Consent Form

Logan Zero and approved partners of Advance to Zero are collecting information from you as part of our efforts to better understand your needs to access housing services.

As part of this survey we may collect personal and sensitive information about you. We take protecting you and your information very seriously. You do not have to answer questions if you do not wish to.

We do not sell, share or disclose your information to anyone outside of Logan Zero and authorised agencies we work with as part of *Advance to Zero*.

By participating in this survey, you give your permission to Logan Zero and authorised agencies to release all relevant housing, health care and social support information about you to progress your access to housing, health care and support services. Only information essential to providing services and improving your access to housing, health care and welfare services will be shared.

The collective findings from this survey which do not identify you individually will also be used to inform government, non-government agencies, research and the community about the needs and experiences of people experiencing homelessness.

You are entitled to request from us a copy of Logan Zero *Privacy and Confidentiality Policy* and the *Partner Confidentiality Agreement* signed by the authorised agencies at any time for free.

I understand that:

- My information will be entered into a secure database
- I have the right to review my information at no cost to me by making a request to any participating member of Logan Zero
- I can request my information be removed from Logan Zero' and authorised agencies' files at any time
- If any information about me is incorrect, or has changed I have the right to request that the information be corrected or updated.

I give consent to the use or disclosure of all personal and sensitive information which is held in any format, written, verbal, audio-visual or otherwise.

Print Name of Person: _____

Date: ____ / ____ / ____

Signature of Person: _____

Verbal Consent Provided



Photograph Use Permission

Logan Zero and approved partners for *Advance to Zero* request permission to take your photo for the purpose of identifying you as part of this advocacy project. With your permission, we may also like to use the photograph in printed publications, websites, social media and other communications materials as part of telling the story of this survey project. Please select from below:

- I agree to the use of my photograph for the purpose of identifying me as part of this survey project only

- I agree to the use of my photograph for the purpose of identifying me and for release to the media, internet and social media as part of telling the story of this survey project, and would like to be identified as:

- I do not agree to being photographed

Print Name of Person: _____

Date: ____ / ____ / ____

Signature of Person: _____



Administration

Agency name		Interviewer name	Survey location
Survey date <small>DD / MM / YY</small>	Survey time <small>__ : __ am/pm</small>	Team name	Survey postcode

A. Demographics

First name	Nickname	Last name	
In what language do you feel best able to express yourself?			
Date of birth <small>DD / MM / YY</small>	Age	Centrelink Reference Number	Consent to participate <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you identify as			
<input type="checkbox"/> Aboriginal	<input type="checkbox"/> Torres Strait Islander	<input type="checkbox"/> Both	<input type="checkbox"/> Neither <input type="checkbox"/> Declined

B. History of housing and homelessness

1. Where do you sleep most frequently? *(Mark only one)*

<input type="checkbox"/> Beach/Riverbed <input type="checkbox"/> Boarding House/Other Hostel <input type="checkbox"/> Bushland <input type="checkbox"/> Car <input type="checkbox"/> Caravan Park <i>(specify)</i> <input type="checkbox"/> Carpark <input type="checkbox"/> Community housing that I rent <input type="checkbox"/> Construction Site	<input type="checkbox"/> Diversion Centre <input type="checkbox"/> DV Refuge <input type="checkbox"/> Emergency/Crisis Accommodation <input type="checkbox"/> Foster Carer <input type="checkbox"/> Hospital <input type="checkbox"/> Hotel/Motel <input type="checkbox"/> House that I Own/Mortgage <input type="checkbox"/> Indigenous Hostel <input type="checkbox"/> Jail/Juvenile Detention	<input type="checkbox"/> Mental Health Facility <input type="checkbox"/> Park/Parklands <input type="checkbox"/> Private housing that I rent <input type="checkbox"/> Public housing that I rent <input type="checkbox"/> Squat/Cave <input type="checkbox"/> Streets <input type="checkbox"/> Supported Accommodation	<input type="checkbox"/> Tent <input type="checkbox"/> Toilets <input type="checkbox"/> Train/Bus Station <input type="checkbox"/> Watch House/Police Cells <input type="checkbox"/> With Friends/Family Temporarily (Couch Surfing) <input type="checkbox"/> Youth Accommodation Service <input type="checkbox"/> Youth Residential Care <input type="checkbox"/> Other <i>(specify)</i> <input type="checkbox"/> Declined
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2a. Are you sleeping rough right now? Yes No Declined



2b. Where have you slept in the past week? *(Mark all that apply)*

<input type="checkbox"/> Beach/Riverbed	<input type="checkbox"/> Diversion Centre	<input type="checkbox"/> Mental Health Facility	<input type="checkbox"/> Tent
<input type="checkbox"/> Boarding House/Other Hostel	<input type="checkbox"/> DV Refuge	<input type="checkbox"/> Park/Parklands	<input type="checkbox"/> Toilets
<input type="checkbox"/> Bushland	<input type="checkbox"/> Emergency/Crisis Accommodation	<input type="checkbox"/> Private housing that I rent	<input type="checkbox"/> Train/Bus Station
<input type="checkbox"/> Car	<input type="checkbox"/> Foster Carer	<input type="checkbox"/> Public housing that I rent	<input type="checkbox"/> Watch House/Police Cells
<input type="checkbox"/> Caravan Park <i>(specify)</i>	<input type="checkbox"/> Hospital	<input type="checkbox"/> Squat/Cave	<input type="checkbox"/> With Friends/Family Temporarily (Couch Surfing)
<input type="checkbox"/> Carpark	<input type="checkbox"/> Hotel/Motel	<input type="checkbox"/> Streets	<input type="checkbox"/> Youth Accommodation Service
<input type="checkbox"/> Community housing that I rent	<input type="checkbox"/> House that I Own/Mortgage	<input type="checkbox"/> Supported Accommodation	<input type="checkbox"/> Youth Residential Care
<input type="checkbox"/> Construction Site	<input type="checkbox"/> Indigenous Hostel		<input type="checkbox"/> Other <i>(specify)</i>
	<input type="checkbox"/> Jail/Juvenile Detention		<input type="checkbox"/> Declined

3. What is the total length of time you have ever lived on the streets or in emergency accommodation?	years	months	<input type="checkbox"/> Declined
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4. How long has it been since you lived in permanent, stable housing (with a secure lease/tenancy)?	years	months	<input type="checkbox"/> Declined
<input type="checkbox"/> Never lived in my own place			

5a. In the last year, how many times have you been homeless?	times	<input type="checkbox"/> Declined
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5b. Of these times you have been homeless in the past year, how many of these times (1 or more days) have you been sleeping rough?	times	<input type="checkbox"/> Declined
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6 a) What age were you when you first slept on the streets or in emergency accommodation?	<input type="checkbox"/> Declined
Age or approximate age: <input type="checkbox"/> Never slept on the streets or in emergency accommodation	

b) If you were with your family at the time, what age were you when you first slept on the streets or in emergency accommodation without a parent/guardian?	<input type="checkbox"/> Declined
Age or approximate age: <input type="checkbox"/> Not applicable	



C. Risks

Questions	Response	Declined
7. In the past six months, <u>how many times</u> have you...		
a) Received health care at <i>Accident and Emergency</i> at the hospital?	times	<input type="checkbox"/>
b) Taken an ambulance to the hospital?	times	<input type="checkbox"/>
c) Been hospitalised as an inpatient in a medical, surgical or maternity unit?	times	<input type="checkbox"/>
d) Been hospitalised as an inpatient in a specialised mental healthcare facility?	times	<input type="checkbox"/>
e) Used a crisis service, including any phone hotlines?	times	<input type="checkbox"/>
f) Talked to the police because you witnessed a crime, were the victim of a crime or the alleged perpetrator of a crime or because the police told you that you must move along?	times	<input type="checkbox"/>
g) Stayed one or more nights in a watch house, juvenile detention or jail, whether that was a short-term stay, a longer stay for a more serious offence, or anything in between?	times	<input type="checkbox"/>

Questions	Yes	No	Declined
For Questions 8 and 9, do not ask if partner is present			
8. Are you currently being harmed or at risk of being harmed by another person such as a spouse, parent, relative or friends?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you experienced violence or threats or violence, such as punching, kicking, attempted strangulation, use of weapons or controlling behavior, in the last six months, that has had an impact on feeling safe?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you been physically harmed or verbally abused during a period of homelessness?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you thought about, threatened to, or tried to harm yourself or anyone else in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Have you ever thought that you could be a danger to other people’s safety?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. When it comes to homelessness services or housing, do you feel you have ever been discriminated against because of things like your age, race, appearance, disabilities, gender identity or sexual orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult for you to rent a place to live?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Were you ever incarcerated when younger than age 18?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Does anybody force or stand over you to do things that you do not want to do?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Is there anyone who has threatened you or whom you are afraid of?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



D. Socialisation and Daily Functioning

Questions	Yes	No	Declined
18. Is there anyone who thinks you owe them money, such as a past landlord, business or bookie?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Do you have any money coming in on a regular basis, through a job, government benefit, cash in hand work, or anything like that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you ever gamble with money that you cannot afford to lose or have debts associated with gambling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Are you usually bored or on most days lacking planned things that you enjoy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Are you currently able to take care of basic needs like bathing, changing clothes, using a toilet, getting food and clean water and other things like that?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Is your current homelessness or lack of stable housing caused by any of the following:			
a) A relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Because you ran away from your family home, residential care or a foster home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Because of conflicts around gender identity or sexual orientation?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Because of violence between family members?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Because of an unhealthy or abusive relationship either at home or elsewhere?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



E. Wellness

Questions	Yes	No	Declined
24. Do you have now, have you ever had, or has a health care provider ever told you that you have any of the following medical conditions:			
a) Cellulitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Kidney disease/end-stage renal disease or dialysis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Liver disease, cirrhosis, or end-stage liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Heart disease, arrhythmia, or irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Emphysema/ Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Hepatitis C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Chronic digestive condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Do you have now, have you ever had, or has a health care provider ever told you that you have any of the following medical conditions:			
a) History of frostbite, hypothermia, or immersion foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) HIV+/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) History of heat stroke/heat exhaustion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Dental problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Foot/skin infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Scabies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Dehydration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k) Other (specify):			
26. Do you avoid or are you unable to go for care when you are not feeling well?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



27. If “No” to Q.26, where do you usually go for health care or when you’re not feeling well?

<p>Hospital</p> <input type="checkbox"/> Logan Hospital <input type="checkbox"/> P.A. Hospital <input type="checkbox"/> Other Hospital	<p>Other Specialist Health Services</p> <input type="checkbox"/> Footprints <input type="checkbox"/> Metro South <input type="checkbox"/> Aboriginal and Torres Strait Islander Health Clinics <input type="checkbox"/> Stride <input type="checkbox"/> Headspace <input type="checkbox"/> Ladders <input type="checkbox"/> Lives Lived Well <input type="checkbox"/> Open Minds <input type="checkbox"/> National Disability Insurance Scheme <input type="checkbox"/> Maternity Hub <input type="checkbox"/> Psychologists <input type="checkbox"/> Other Specialist Health Service	<input type="checkbox"/> Other (<i>Specify</i>) Who Where <input type="checkbox"/> Declined
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Questions	Yes	No	Declined
28. Have you ever had to leave housing, crisis accommodation, or other place you were staying because of your physical health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Do you have any physical disability that would limit the type of housing you could access, or make it hard to live independently, because you would need help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Are you currently pregnant, ever been pregnant or ever gotten someone pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or been told you do – including any issues with using medicines in a way you weren't supposed to or using over-the-counter medications to get high?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. Have you consumed alcohol and/or drugs almost every day or every day for the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. a) Have you injected drugs in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) If so, are you aware of safe injecting practices?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Have you blacked out because of your alcohol or drug use in the past month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. Has your drinking or drug use led you to being kicked out of any housing, accommodation or program you were staying at in the past?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. If you've ever used marijuana, did you ever try it at age 12 or younger?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Questions	Yes	No	Declined
39. Have you ever been diagnosed with any of the following:			
a) Anxiety (other than PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) Post-Traumatic Stress Disorder (PTSD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) Bipolar Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) Schizophrenia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) Psychosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) Borderline Personality Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) Obsessive Compulsive Disorder (OCD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) Eating disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j) Other mental health condition (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. a) Have you ever been taken to a hospital against your will for a mental health reason?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Have you ever gone to the <i>Accident and Emergency</i> at the hospital because you weren't feeling 100% well emotionally or because of your nerves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
42. Have you voluntarily spoken with a psychiatrist, psychologist or other mental health professional in the last 6 months because of your mental health?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
43. Have you ever had a serious brain injury (ABI) or head trauma?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
44. Have you ever been told you have a learning disability or developmental/intellectual disability?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
45. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Questions	Yes	No	Declined
46. Are there any medications a doctor said you should be taking that you are not taking as advised because:			
a) You sell them instead of taking them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) You misuse them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) You have had them taken or stolen from you	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) You forget to take them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e) You are unable to store them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f) You are unable to afford them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g) You do not agree that you need them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h) You do not like the side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i) For any other reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Additional Questions

<p>Your Gender is best described as</p> <p><input type="checkbox"/> Female</p> <p><input type="checkbox"/> Male</p> <p><input type="checkbox"/> Sistergirl</p> <p><input type="checkbox"/> Brotherboy</p> <p><input type="checkbox"/> Transgender</p> <p><input type="checkbox"/> Gender diverse</p> <p><input type="checkbox"/> Non-binary</p> <p><input type="checkbox"/> Questioning/Unsure</p> <p><input type="checkbox"/> Prefer not to say</p> <p><input type="checkbox"/> Prefer to self-describe (specify)</p> <p><input type="checkbox"/> Declined</p>	<p>Intersex variation:</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> Unsure</p> <p><input type="checkbox"/> No <input type="checkbox"/> Prefer not to say</p> <p><input type="checkbox"/> Declined</p>												
<p>Your Sexual Identity is best described as</p> <table border="0"> <tr> <td><input type="checkbox"/> Asexual</td> <td><input type="checkbox"/> Queer</td> </tr> <tr> <td><input type="checkbox"/> Bisexual</td> <td><input type="checkbox"/> Questioning/Unsure</td> </tr> <tr> <td><input type="checkbox"/> Gay</td> <td><input type="checkbox"/> Prefer to self-describe (specify)</td> </tr> <tr> <td><input type="checkbox"/> Heterosexual</td> <td><input type="checkbox"/> Prefer not to say</td> </tr> <tr> <td><input type="checkbox"/> Lesbian</td> <td><input type="checkbox"/> Declined</td> </tr> <tr> <td><input type="checkbox"/> Pansexual</td> <td></td> </tr> </table>		<input type="checkbox"/> Asexual	<input type="checkbox"/> Queer	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Questioning/Unsure	<input type="checkbox"/> Gay	<input type="checkbox"/> Prefer to self-describe (specify)	<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Prefer not to say	<input type="checkbox"/> Lesbian	<input type="checkbox"/> Declined	<input type="checkbox"/> Pansexual	
<input type="checkbox"/> Asexual	<input type="checkbox"/> Queer												
<input type="checkbox"/> Bisexual	<input type="checkbox"/> Questioning/Unsure												
<input type="checkbox"/> Gay	<input type="checkbox"/> Prefer to self-describe (specify)												
<input type="checkbox"/> Heterosexual	<input type="checkbox"/> Prefer not to say												
<input type="checkbox"/> Lesbian	<input type="checkbox"/> Declined												
<input type="checkbox"/> Pansexual													



<p>What country were you born in?</p> <p><input type="checkbox"/> Australia</p> <p><input type="checkbox"/> New Zealand</p> <p><input type="checkbox"/> United Kingdom</p> <p><input type="checkbox"/> China</p> <p><input type="checkbox"/> India</p> <p><input type="checkbox"/> Philippines</p> <p><input type="checkbox"/> Vietnam</p> <p><input type="checkbox"/> Italy</p> <p><input type="checkbox"/> South Africa</p> <p><input type="checkbox"/> Malaysia</p> <p><input type="checkbox"/> Other (<i>specify</i>)</p> <p><input type="checkbox"/> Declined</p>	<p>What is your ancestry / ethnic cultural background? (<i>Mark all that apply</i>)</p> <p><input type="checkbox"/> Australian</p> <p><input type="checkbox"/> Indigenous Australian</p> <p><input type="checkbox"/> English</p> <p><input type="checkbox"/> Irish</p> <p><input type="checkbox"/> Scottish</p> <p><input type="checkbox"/> Italian</p> <p><input type="checkbox"/> German</p> <p><input type="checkbox"/> Chinese</p> <p><input type="checkbox"/> Greek</p> <p><input type="checkbox"/> Vietnamese</p> <p><input type="checkbox"/> Hmong</p> <p><input type="checkbox"/> Kurdish</p> <p><input type="checkbox"/> Maori</p> <p><input type="checkbox"/> Lebanese</p> <p><input type="checkbox"/> Other (<i>specify</i>)</p> <p><input type="checkbox"/> Declined</p>	<p>What is your citizenship or residency status?</p> <p><input type="checkbox"/> Australian citizen</p> <p><input type="checkbox"/> Australian permanent resident</p> <p><input type="checkbox"/> Visitor Visa</p> <p><input type="checkbox"/> Working and Skilled Visa</p> <p><input type="checkbox"/> Studying and Training Visa</p> <p><input type="checkbox"/> Family and Spousal Visa</p> <p><input type="checkbox"/> Refugee and Humanitarian Visa</p> <p><input type="checkbox"/> Bridging Visa</p> <p><input type="checkbox"/> New Zealand citizen</p> <p><input type="checkbox"/> Other (<i>specify</i>)</p> <p><input type="checkbox"/> Decline to state</p>
<p>How do you make money? (<i>Mark all that apply</i>)</p> <p><input type="checkbox"/> Aged Pension</p> <p><input type="checkbox"/> Any other pension/allowance</p> <p><input type="checkbox"/> Begging</p> <p><input type="checkbox"/> Carer Allowance</p> <p><input type="checkbox"/> Carer Payment</p> <p><input type="checkbox"/> Disability Support Pension</p> <p><input type="checkbox"/> Family Tax Benefit</p> <p><input type="checkbox"/> Maintenance (Child Support)</p> <p><input type="checkbox"/> New Start/Unemployment Benefit</p> <p><input type="checkbox"/> No Income</p> <p><input type="checkbox"/> Parenting Payment</p> <p><input type="checkbox"/> Rent Assistance</p> <p><input type="checkbox"/> Sex Work</p>	<p><input type="checkbox"/> Special Benefit Payment</p> <p><input type="checkbox"/> Student Allowance</p> <p><input type="checkbox"/> Work, Big Issue Vendor</p> <p><input type="checkbox"/> Work, Employee</p> <p><input type="checkbox"/> Work, Self-Employed</p> <p><input type="checkbox"/> Worker's Compensation</p> <p><input type="checkbox"/> Youth Allowance – Living at Home</p> <p><input type="checkbox"/> Youth Allowance – Living Away from Home</p> <p><input type="checkbox"/> Other (<i>specify</i>)</p> <p><input type="checkbox"/> None of the Above</p> <p><input type="checkbox"/> Declined</p>	<p>Are your finances administered by:</p> <p><input type="checkbox"/> Public Trustee</p> <p><input type="checkbox"/> Carer</p> <p><input type="checkbox"/> Relative</p> <p><input type="checkbox"/> Other (<i>specify</i>)</p> <p><input type="checkbox"/> N/A (self managed)</p> <p><input type="checkbox"/> Declined</p> <p>Do you have a Guardian?</p> <p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Declined</p>

Questions	Yes	No	Declined
47. Are you a current serving member of the Australian Defence Force?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
48. Have you ever served in the Australian Defence Force?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
49. Have you ever been in foster care, out of home care or institutional care as a child?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50. Have you ever been in youth detention?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
51. Please specify if you have any pets:			



Follow-up Questions

<p>On a regular day, where is it easiest to find you and what time of day is easiest to do so?</p>	<p>Place: _____</p> <p>Time: __:__am/pm or <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening</p>
<p>Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?</p>	<p>Phone: _____</p> <p>Email: _____</p>
<p>What do you need to be safe and well?</p>	<p>_____</p> <p>_____</p>

