

Identifying
First Name*: _____ **Last Name*:** _____

Client has nickname
Nickname _____

Birth Date*: _____
 Full DOB
 Partial (MM/YY)
 Partial (DD/YY)

Age: _____
 Client doesn't know
 Refused
 Data not collected

Gender*

-
- Male
-
-
- Female
-
-
- Transgender Male to Female
-
-
- Transgender Female to Male
-
-
- Client Refused
-
-
- Other _____

Social Security#*: _____

-
- Full
-
-
- Partial
-
-
- Client doesn't know
-
-
- Refused
-
-
- Data Not Collected

Which VI SPDAT would you like to fill out for this client*?
 Family

Citizenship Status

-
- U.S. Citizen
-
- U.S. National
-
- Undocumented
-
-
- Eligible Non-Citizen
 (American Samoa or Swains Island)
-
- Client doesn't know
-
-
- Non-US Citizen COFA
-
- Ineligible Non-Citizen
-
- Client refused
-
-
- Data Not Collected

Language in which client is best able to express him/herself *

-
- Chinese
-
- Japanese
-
- Tagalog
-
-
- Chuukese
-
- Korean
-
- Vietnamese
-
-
- English
-
- Marshallese
-
- Other _____
-
-
- Ilocano
-
- Spanish

Has client ever served in the US Military?*
 Yes
 No
 Refused

Sharing
Relationship to Head of Household*
 Self (H of H)

Sharing*
 Shared
 Not Shared

Add Family Member (Children)

First Name*:	Last Name*:	Birth Date*:	Age:	Gender*:
1) _____	_____	_____	_____	_____
Relationship to Head of Household*		Social Security#*:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative	_____	<input type="checkbox"/> Full DOB	<input type="checkbox"/> Male
<input type="checkbox"/> Child	<input type="checkbox"/> Other Non-Relative		<input type="checkbox"/> Partial (MM/YY)	<input type="checkbox"/> Female
<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unknown	<input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Partial (DD/YY)	<input type="checkbox"/> Trans M-F
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Trans F-M
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster-Child	<input type="checkbox"/> Refused	<input type="checkbox"/> Client refused	<input type="checkbox"/> Refused
		<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other

Add Family Member (Children) - Continued

First Name*: 2) _____	Last Name *: _____	Birth Date*: _____	Age: _____	Gender*: _____
Relationship to Head of Household*		Social Security#*:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative	_____	<input type="checkbox"/> Full DOB	<input type="checkbox"/> Male
<input type="checkbox"/> Child	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Partial (MM/YY)	<input type="checkbox"/> Female
<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unknown	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Partial (DD/YY)	<input type="checkbox"/> Trans M-F
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Refused	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Trans F-M
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster-Child	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client refused	<input type="checkbox"/> Refused
			<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other

First Name*: 3) _____	Last Name *: _____	Birth Date*: _____	Age: _____	Gender*: _____
Relationship to Head of Household*		Social Security#*:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative	_____	<input type="checkbox"/> Full DOB	<input type="checkbox"/> Male
<input type="checkbox"/> Child	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Partial (MM/YY)	<input type="checkbox"/> Female
<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unknown	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Partial (DD/YY)	<input type="checkbox"/> Trans M-F
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Refused	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Trans F-M
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster-Child	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client refused	<input type="checkbox"/> Refused
			<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other

First Name*: 4) _____	Last Name *: _____	Birth Date*: _____	Age: _____	Gender*: _____
Relationship to Head of Household*		Social Security#*:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative	_____	<input type="checkbox"/> Full DOB	<input type="checkbox"/> Male
<input type="checkbox"/> Child	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Partial (MM/YY)	<input type="checkbox"/> Female
<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unknown	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Partial (DD/YY)	<input type="checkbox"/> Trans M-F
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Refused	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Trans F-M
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster-Child	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client refused	<input type="checkbox"/> Refused
			<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other

First Name*: 5) _____	Last Name *: _____	Birth Date*: _____	Age: _____	Gender*: _____
Relationship to Head of Household*		Social Security#*:		
<input type="checkbox"/> Spouse	<input type="checkbox"/> Other Relative	_____	<input type="checkbox"/> Full DOB	<input type="checkbox"/> Male
<input type="checkbox"/> Child	<input type="checkbox"/> Other Non-Relative	<input type="checkbox"/> Full <input type="checkbox"/> Partial	<input type="checkbox"/> Partial (MM/YY)	<input type="checkbox"/> Female
<input type="checkbox"/> Step-Child	<input type="checkbox"/> Unknown	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Partial (DD/YY)	<input type="checkbox"/> Trans M-F
<input type="checkbox"/> Grandparent	<input type="checkbox"/> Grandchild	<input type="checkbox"/> Refused	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Trans F-M
<input type="checkbox"/> Guardian	<input type="checkbox"/> Foster-Child	<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Client refused	<input type="checkbox"/> Refused
			<input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Other

To add additional family members, please use VI Family additional member form page 2a.

VI SPDAT Enrollment Add/Edit

Program Entry Date*: _____

Program (County)*: _____

Provider*: _____

Restricted Information* Shared Not Shared

General Information/Consent

Family Or Individual* (HMIS Self Populates) _____ **Interviewer's Name*:** _____
 Staff
Survey Date and Time*: _____ **Position*:** Team Volunteer
Interview location*: _____ **Has Consented to Participate*:** Yes No
Is there a second parent currently part of the household? * Yes No **Second Parent's Name*:** _____

Children

1. How many children under the age of 18 are currently with you? * _____ Answered Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? * _____ Answered Refused
3. Is any member of the family currently pregnant? * Yes No Refused

A. Housing

5. Where do you and your family sleep most frequently? *
 Shelters Outdoors
 Transitional Housing Refused
 Safe Haven Other _____
6. How long has it been since you and your family lived in permanent stable housing (in months)? * _____ Answered Refused
7. In the last three years, how many times have you and your family been homeless? * _____ Answered Refused

B. Risks

For 8a-8d -- In the past six months, how many times have you or anyone in your family:

8a. received health care at an emergency department/room? * _____ Answered Refused **8b.** taken an ambulance to the hospital? * _____ Answered Refused
8c. been hospitalized as an inpatient? * _____ Answered Refused **8d.** used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? * _____ Answered Refused
8e. talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? * _____ Answered Refused **8f.** stayed 1 or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? * _____ Answered Refused

B. Risks (Continued)

9. Have you or anyone in your family been attacked or beaten up since they've become homeless?*

Yes
 No
 Refused

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live?*

Yes
 No
 Refused

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do?*

Yes
 No
 Refused

10. Have you or anyone in your family threatened to or tried to harm yourself or anyone else in the last year?*

Yes
 No
 Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that?*

Yes
 No
 Refused

C. Socialization

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money?*

Yes
 No
 Refused

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled?*

Yes
 No
 Refused

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted?*

Yes
 No
 Refused

15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?*

Yes
 No
 Refused

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?*

Yes
 No
 Refused

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family?*

Yes
 No
 Refused

21. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family?*

Yes
 No
 Refused

23. When someone in your family is sick or not feeling well, does your family avoid getting medical help?*

Yes
 No
 Refused

20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart?*

Yes
 No
 Refused

22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?*

Yes
 No
 Refused

24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?*

Yes
 No
 Refused

D. Wellness (Continued)

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?*

Yes
 No
 Refused

26b. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a past head injury?*

Yes
 No
 Refused

27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed?*

Yes
 No
 Refused

29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking?*

Yes
 No
 Refused

31. Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced?*

Yes
 No
 Refused

26a. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a mental health issue or concern?*

Yes
 No
 Refused

26c. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of a learning disability, developmental disability, or other impairment?*

Yes
 No
 Refused

CONDITIONAL QUESTION: Based on answers provided for questions #19-27.

28. Does any single member of your household have a medical condition, mental health concerns, and experience with problematic substance use?*

Yes
 No
 Refused

30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication?*

Yes
 No

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days?*

Yes
 No
 Refused

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?*

Yes
 No
 Refused

CONDITIONAL QUESTION: IF THERE ARE SCHOOL-AGED CHILDREN:

Yes
 No
 Refused

36. Do your children attend school more often than not each week?*

37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?*

Yes
 No
 Refused

33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?*

Yes
 No
 Refused

35. Has any child in the family experienced abuse or trauma in the last 180 days?*

Yes
 No
 Refused

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?*

Yes
 No
 Refused

E. Family Unit (Continued)

39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?

Yes
 No
 Refused

40b. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult 2 or more hours per day for children aged 12 or younger?*

Yes
 No
 Refused

40a. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult 3 or more hours per day for children aged 13 or older?*

Yes
 No
 Refused

CONDITIONAL QUESTION: IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:

Yes
 No
 Refused

41. Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?*

Follow-Up Questions

Survey Region*

- Downtown Honolulu - Salt Lake to Piikoi St
- East Honolulu: Piikoi St. to Hawaii Kai, Waikiki
- Ewa - Aiea to Kapolei
- Windward: Kaneohe to Waimanalo
- Upper Windward Kahaluu to Kahuku
- North - Wahiawa to North Shore
- Waianae Coast
- Other _____

Where do you usually go for healthcare or when you're not feeling well?*

- Hospitals: *For Oahu Only, please select*
 - Castle Medical Center
 - Kaiser Medical Center Honolulu/Moanalua
 - Kapiolani/Pali Momi Medical Center
 - Straub Clinic and Hospital
 - Queens Medical Center
- Clinics: *For Oahu Only, please select*
 - Kalihi Palama Health Center
 - Waikiki Health Center
 - Waimanalo Health Center
 - Waianae Coast Comprehensive Health Center
- VA
- Other: Specify: _____
- Does Not Go For Care

Additional Follow-Up Questions (Continued)

Where did you live prior to becoming homeless?*

Oahu Kauai U.S. Mainland (State) _____

Hawaii Island Molokai Other _____

Maui Lanai

Have you or anyone in your household served in the U.S. military?* Yes No

Which war/war era?*

<input type="checkbox"/> Persian Gulf Era (August 1991 – Present)	<input type="checkbox"/> World War II (September 1940 – July 1947)
<input type="checkbox"/> Post Vietnam (May 1975 – July 1991)	<input type="checkbox"/> Post September 11, 2001 (September 11, 2001 -Present)
<input type="checkbox"/> Vietnam Era (August 1964 – April 1975)	<input type="checkbox"/> Afghanistan/Iraq
<input type="checkbox"/> Between Korean and Vietnam War (Feb 1955– July 1964)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Korean War (June 1950 – January 1955)	<input type="checkbox"/> Won't answer
<input type="checkbox"/> Between WWII and Korean War (Aug 1947 – May 1950)	<input type="checkbox"/> Other

What was your discharge status?*

<input type="checkbox"/> Honorable	<input type="checkbox"/> Uncharacterized
<input type="checkbox"/> General under honorable	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Under other than honorable conditions	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Bad conduct	<input type="checkbox"/> Data not collected
<input type="checkbox"/> Dishonorable	

What kind of insurance do you have?*

<input type="checkbox"/> Medicaid	<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Insurance
<input type="checkbox"/> VA	<input type="checkbox"/> None	Other_____

Medical Plan Name*

<input type="checkbox"/> Alohacare	<input type="checkbox"/> HMSA	<input type="checkbox"/> Kaiser	<input type="checkbox"/> Medicare	<input type="checkbox"/> Ohana
<input type="checkbox"/> United Healthcare	<input type="checkbox"/> Not Sure	<input type="checkbox"/> Other	<input type="checkbox"/> VA	

Type of Private Insurance* _____

Has client established behavioral health case management coverage through the Adult Mental Health Division (AMHD) or Community Care Services (CCS)?

<input type="checkbox"/> AMHD	<input type="checkbox"/> Pending
<input type="checkbox"/> CCS	<input type="checkbox"/> None

Surveyor: Is this client a verified user of emergency services?*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Refused	<input type="checkbox"/> Data Not Collected	

Surveyor: Is the client a verified frequent user of high level mental health services (MH-1)?*

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Refused	<input type="checkbox"/> Data Not Collected	

Is there a phone number where someone can safely get in touch with you or leave you a message? _____

Is there an email where someone can safely get in touch with you or leave a message? Confirm this email _____

On a regular day, where is it easiest to find you? _____

What time of day is it easiest to do so?

<input type="checkbox"/> Specific Time _____	<input type="checkbox"/> Morning (8 am – Noon)	<input type="checkbox"/> Evening (4 – 8 pm)
	<input type="checkbox"/> Afternoon (Noon – 4pm)	<input type="checkbox"/> Night (8 pm – 12 midnight)

Ok, I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Refused	<input type="checkbox"/> Data Not Collected	