



### HMIS Individual Exit (05-10-2016)

(FOR AGENCY USE ONLY)

Program Exit Date: \_\_\_/\_\_\_/\_\_\_ Program Name/Grant: \_\_\_\_\_

Is Client the Head of Household?  Yes  No

Legal First Name: \_\_\_\_\_ Legal Middle Name: \_\_\_\_\_

Legal Last Name: \_\_\_\_\_ Suffix: \_\_\_\_\_

#### Program Exit

Destination: (choose one):	
<input type="checkbox"/> Deceased	<input type="checkbox"/> Rental by client, with VASH Housing Subsidy
<input type="checkbox"/> Emergency shelter, including hotel/motel paid for with emergency shelter voucher	<input type="checkbox"/> Rental by client, with GPD TIP subsidy
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<input type="checkbox"/> Hotel or motel paid for without an emergency shelter voucher	<input type="checkbox"/> Safe Haven
<input type="checkbox"/> Jail, prison or other juvenile detention facility	<input type="checkbox"/> Staying or Living with Family, permanent tenure
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Staying or Living with Family, temporary tenure (e.g. room, apartment or house)
<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH	<input type="checkbox"/> Staying or Living with Friends, permanent tenure
<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH	<input type="checkbox"/> Staying or Living with Friends, temporary tenure (e.g. room, apartment or house)
<input type="checkbox"/> Owned by client, no on-going housing subsidy	<input type="checkbox"/> Substance abuse treatment facility or detox center
<input type="checkbox"/> Owned by client, with on-going housing subsidy	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
<input type="checkbox"/> Permanent housing for formerly homeless persons (such as: CoC project; HUD legacy programs; HOPWA PH)	<input type="checkbox"/> Other _____
<input type="checkbox"/> Place not meant for habitation (e.g. vehicle, abandoned building, bus/train/subway station/airport, or anywhere outside)	<input type="checkbox"/> No exit interview completed
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Client Doesn't Know
<input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Client Refused

Destination Address: \_\_\_\_\_ City: \_\_\_\_\_

County \_\_\_\_\_ State/Province \_\_\_\_\_ Zip Code \_\_\_\_\_

Health Information				
<b>Do you have a physical disability?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and its severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Do you have a developmental disability?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and its severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Do you have a chronic health condition?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and its severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Have you been diagnosed with AIDS or have you tested positive for HIV?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is it expected to substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and its severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If yes, are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<b>Do you feel that you have a mental health problem?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and its severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
If you have a mental health problem: Are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
Mental Health: If yes for condition how confirmed?	<input type="checkbox"/> Unconfirmed; presumptive or self-report	<input type="checkbox"/> Confirmed through assessment and clinical evaluation	<input type="checkbox"/> Confirmed by prior evaluation or clinical records	
Mental Health: Serious mental illness (SMI) and if SMI how confirmed.	<input type="checkbox"/> No	<input type="checkbox"/> Unconfirmed; presumptive or self-report	<input type="checkbox"/> Confirmed by prior evaluation or clinical records	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Data not Collected <input type="checkbox"/> Client Refused
<b>Do you have a drug or alcohol problem?</b>	<input type="checkbox"/> Alcohol <input type="checkbox"/> Drug <input type="checkbox"/> Both	<input type="checkbox"/> No	Know	<input type="checkbox"/> Client Refused
If yes, is it expected to be of long-continued and indefinite duration and substantially impair your ability to live independently?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
If yes, is there documentation of the disability and severity on file?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Know	
If yes, are you currently receiving services or treatment for this condition?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused

## **INCOME & BENEFITS**

Please remember to update the income, benefits & healthcare on the snapshot management tab before finalizing the exit.

Income Source ( <i>Choose all that applies</i> ) <b>Note: All PAY INTERVALS should be Monthly</b>	Stated Income	Documentation
<input type="checkbox"/> No Financial Resources		
<input type="checkbox"/> Earned Income (i.e. employment income)	\$_____	
<input type="checkbox"/> Unemployment Insurance	\$_____	
<input type="checkbox"/> Supplemental Security Income (SSI)	\$_____	
<input type="checkbox"/> Social Security Disability Income (SSDI)	\$_____	
<input type="checkbox"/> Veteran's Service-Connected Disability Compensation	\$_____	
<input type="checkbox"/> Veteran's Non-Service-Connected Disability Compensation	\$_____	
<input type="checkbox"/> Private Disability Insurance	\$_____	
<input type="checkbox"/> Worker's Compensation	\$_____	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	\$_____	
<input type="checkbox"/> General Assistance (GA)	\$_____	
<input type="checkbox"/> Retirement Income from Social Security	\$_____	
<input type="checkbox"/> Pension from Former Job	\$_____	
<input type="checkbox"/> Child Support	\$_____	
<input type="checkbox"/> Alimony/Other Spousal Support	\$_____	
<input type="checkbox"/> Aid to the Needy and Disabled (AND)	\$_____	
<input type="checkbox"/> Old Age Pension (OAP)	\$_____	
<input type="checkbox"/> Other Sources	\$_____	
<input type="checkbox"/> Client Doesn't Know		
<input type="checkbox"/> Client Refused		
<b>Non-Cash Benefits (<i>Choose all that applies</i>)</b>		
<input type="checkbox"/> None <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Other Benefit Source:_____		
<input type="checkbox"/> Food Stamps/SNAP \$_____ (amount optional) <input type="checkbox"/> TANF Child Care <input type="checkbox"/> Temporary Rental Assistance		
<input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Section 8 or Rental Assistance		
<input type="checkbox"/> WIC (Women, Infants and Children) <input type="checkbox"/> Other TANF-funded Services		
<b>Health Insurance</b>		
<input type="checkbox"/> No Health Insurance <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Other_____		
<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Childrens Health Insurance <input type="checkbox"/> Veteran's - VA Medical Services		
<input type="checkbox"/> Employer provided Health Insurance <input type="checkbox"/> COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Adult Health Insurance		

Educational Level (choose one):			
<input type="checkbox"/> No Schooling Completed	<input type="checkbox"/> Nursery to 4 <sup>th</sup> Grade	<input type="checkbox"/> 5 <sup>th</sup> or 6 <sup>th</sup> Grade	<input type="checkbox"/> 7 <sup>th</sup> or 8 <sup>th</sup> Grade
<input type="checkbox"/> 9 <sup>th</sup> Grade	<input type="checkbox"/> 10 <sup>th</sup> Grade	<input type="checkbox"/> 11 <sup>th</sup> Grade	<input type="checkbox"/> 12 <sup>th</sup> Grade, No diploma
<input type="checkbox"/> High School Diploma	<input type="checkbox"/> GED	<input type="checkbox"/> Post-Secondary	<input type="checkbox"/> 4 year College
<input type="checkbox"/> Graduate School	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Unknown

**Note: This section is for special programs that require additional question sets.**

<b>HOPWA QUESTIONS</b> <i>(Only answer these questions for HOPWA programs)</i>	
<b>Information Date:</b> ____/____/____	
<b>Receiving Public HIV/AIDS Medical Assistance:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>Reason (if no):</b> <input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<b>Receiving AIDS Drug Assistance Program (ADAP):</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	
<b>Reason (if no):</b> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> <input type="checkbox"/> Insurance type N/A for this client	
<b>Information Date:</b> ____/____/____	
<b>T-Cell (CD4) Count Available:</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
<b>Reason (if no):</b> <input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	

<b>PATH</b>	
Date of Status Determination ____/____/____	Client Became Enrolled in PATH: <input type="checkbox"/> No <input type="checkbox"/> Yes
(if no) Reason Not Enrolled: <input type="checkbox"/> Client was found ineligible for PATH <input type="checkbox"/> Client was not enrolled for other reason(s)	
Connection with SOAR: <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_