2023 CoC HMIS Exit Form - Adult

PROJECT EXIT DATE (e.g., 09/20/2023)

The Project Exit Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/	2	0	2	
		Month			Day			Year	

CLIENT (name or other identifier)

DESTINATION

☐	Place not meant for habitation (e.g.,a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	☐	Staying or living with friends, permanent tenure
☐	Safe Haven	☐	Moved from one HOPWA funded project to HOPWA PH
☐	Foster care home or foster care group home	☐	Rental by client, no ongoing housing subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with ongoing housing subsidy (Subsidy Type _____)
☐	Jail, prison, or juvenile detention facility	☐	Owned by client, with ongoing housing subsidy
☐	Long-term care facility or nursing home	☐	Owned by client, no ongoing housing subsidy
☐	Psychiatric hospital or other psychiatric facility	☐	Client doesn't know
☐	Substance abuse treatment facility or detox center	☐	Client Prefers Not to Answer
☐	Staying or living with family, temporary tenure (e.g., room, apartment or house)	☐	Deceased
☐	Transitional housing for homeless persons (including homeless youth)	☐	Other (Describe) _____
☐	Residential Project or halfway house with no homeless criteria	☐	No exit interview completed
☐	Hotel or motel paid for without emergency shelter voucher	☐	Data Not Collected
☐	Post Home (non-crisis)		
☐	Moved from one HOPWA funded project to HOPWA TH		
☐	Staying or living with friends, temporary tenure (e.g., room apartment or house)		
☐	Staying or living with family, permanent tenure		

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Receiving Non-Cash Benefits?	☐ No ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Yes ☐ Data not collected
IF "YES" TO RECEIVING NON-CASH BENEFITS– INDICATE ALL SOURCES THAT APPLY	
☐ Supplemental Nutrition Assistance Program (SNAP)	☐ TANF Transportation Services
☐ Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐ Other TANF-funded services
☐ TANF Childcare Services	☐ Other Non-Cash Benefits (Specify Source):_____

General Health Status	☐ Excellent ☐ Fair ☐ Client Prefers Not to Answer ☐ Very Good ☐ Poor ☐ Data not collected ☐ Good ☐ Client doesn't know

Checkmark the correct response:

Well Being	Strong disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Strongly agree	Client doesn't know	Client Prefers Not to Answer	Data not collected
Client perceives their life has value and worth.								
Client perceives they have support from others who will listen to problems.								
Client perceives they have a tendency to bounce back after hard times.								

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid.	
Not at all	
Once a month	
Several times a month	
Several times a week	
At least every day	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Substance Use Disorder	
No	
Alcohol Use Disorder	
Drug Use Disorder	
Both Alcohol and Drug Use Disorders	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Mental Health Disorder	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Developmental Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Chronic Health Condition	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

HIV/AIDS	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Physical Disability	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Translation Assistance	
No	
Yes	
Client doesn't know	
Client Prefers Not to Answer	
Data not collected	

Income from Any Source	☐ No ☐ Yes ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY	
Income Source (Check all that apply)	**Monthly Amount**
☐ Earned Income	
☐ Unemployment Insurance	
☐ Worker's Compensation	
☐ Private Disability Insurance	
☐ VA Service-Connected Disability Compensation	
☐ Social Security Disability Income (SSDI)	
☐ Supplemental Security Income (SSI)	
☐ Retirement Income from Social Security	
☐ VA Non-Service-Connected Disability Pension	
☐ Pension or retirement income from a former job	
☐ Temporary Assistance for Needy Families (TANF)	
☐ General Assistance (GA)	
☐ Alimony or other spousal support	
☐ Child Support	
☐ Other Cash Income (Specify:_____)	

Total Monthly Amount $_____

Covered by Health Insurance?	☐ No ☐ Client doesn't know ☐ Client Prefers Not to Answer ☐ Yes ☐ Data not collected

IF "YES" TO COVERED BY HEALTH INSURANCE– INDICATE ALL SOURCES THAT APPLY	
☐ MEDICAID	☐ Insurance Obtained through COBRA
☐ MEDICARE	☐ Private Pay Health Insurance
☐ State Children's Health Insurance Program	☐ State Health Insurance for Adults
☐ Veteran's Administration (VA) Medical Services	☐ Indian Health Services Program
☐ Employer-provided Health Insurance	☐ Other Health Insurance (Specify Source):_____