

-Continuum of Care – Basic Exit

Data Collection HMIS Form — (2021)



Client ID:	Project Exit Date:
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First, Mi., Last Name, Suf:

Reason for leaving:	<input type="checkbox"/> Completed Program	<input type="checkbox"/> Criminal activity/violence	<input type="checkbox"/> Death
	<input type="checkbox"/> Disagreement with rules/persons	<input type="checkbox"/> Left for In-House Supportive Housing	<input type="checkbox"/> Left for housing opp. Before completing program
	<input type="checkbox"/> Need fully met	<input type="checkbox"/> Needs could not be met	<input type="checkbox"/> Non-compliance with program
	<input type="checkbox"/> Nonpayment of rent	<input type="checkbox"/> Planned DC services completed referral made	<input type="checkbox"/> Planned DC services completed, no referral
	<input type="checkbox"/> Reached maximum time allowed	<input type="checkbox"/> Runaway	<input type="checkbox"/> Unknown/Disappeared
	<input type="checkbox"/> Unplanned DC parent/child terminated services	<input type="checkbox"/> Other	<input type="checkbox"/> Temporary financial assistance depleted
	<input type="checkbox"/> Other (Program no longer in operation)	<input type="checkbox"/> No contact for one month	

Assessment Disposition * Note: This section can be found at the end of the exit screen

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <input type="checkbox"/> Referred to emergency shelter/safe haven <input type="checkbox"/> Referred to rapid re-housing <input type="checkbox"/> Referred to homelessness prevention <input type="checkbox"/> Referred to other continuum project type <input type="checkbox"/> Unable to refer/accept within continuum; ineligible for continuum projects <input type="checkbox"/> Referred to other community project (non-continuum) <input type="checkbox"/> Other/specify: | <ul style="list-style-type: none"> <input type="checkbox"/> Referred to transitional housing <input type="checkbox"/> Referred to permanent supportive housing <input type="checkbox"/> Referred to street outreach <input type="checkbox"/> Referred to a homelessness diversion program <input type="checkbox"/> Unable to refer/accept within continuum; continuum services unavailable <input type="checkbox"/> Applicant terminated assessment prior to completion |
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Destination		
Homeless Situation	Institutional Situation	Temporary & Permanent Housing Situation
<input type="checkbox"/> Place not meant for habitation <input type="checkbox"/> Emergency shelter, incl. hotel/motel paid for w/ES voucher, or RHY- funded Host Home Shelter <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility <input type="checkbox"/> Jail, prison, or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Substance abuse treatment facility or detox center <div style="background-color: #e0e0e0; padding: 5px;"> <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected <input type="checkbox"/> No exit interview completed <input type="checkbox"/> Other <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Permanent: In-house supportive housing </div>	<input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host Home (non – crisis) <input type="checkbox"/> Staying or living in a family member's room, apartment or house <input type="checkbox"/> Staying or living in a friend's room, apartment or house <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Renter by client, with other ongoing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy

If "Other", specify:	
Notes:	
Subsidy:	<input type="checkbox"/> None <input type="checkbox"/> Public housing <input type="checkbox"/> Section 8 <input type="checkbox"/> S+C <input type="checkbox"/> HOME Program <input type="checkbox"/> HOPWA Program

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	<input type="checkbox"/> Other housing subsidy	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Refused		
Total Monthly Income: \$ _____ (Income from any source)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of Income	Receiving income from any source?	Amount of income	How often:	Start Date	End Date
Alimony or other spousal support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Child support	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Earned income	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Pension or retirement income from another job	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Private disability insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Retirement income from social security	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
SSDI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
SSI	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
TANF	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Unemployment insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
VA Non- service connected disability pension	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				

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Worker's compensation	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed				
Non cash benefit from any source:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected		

Source of non-cash benefit	Receiving income from any source?	Start Date	End Date
Supplemental Nutritional Assistance Program (Food Stamps)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Special Supplemental Nutrition Program for WIC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
TANF Child Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
TANF Transportation Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Other TANF Funded Services	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		

Covered by health insurance:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected
Source of Health Insurance	Covered	Start Date	End Date
Medicaid	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Medicare	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
State Children's Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Veteran's Admin Medical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Employer Provided Health Insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Health Insurance obtained through COBRA	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Private pay health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
State health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		
Indian health insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed		

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Other	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Data Not Completed	
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Disability Type	Currently Receiving Services or Treatment	Condition Long Term? (Y/N)	Start Date	Disability Determination (Y/N)	Disability Verification on File (Y/N)	End Date
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Both Alcohol and Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Developmental	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client don't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not completed					

Note on Disability:

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