

HMIS Data Collection – EXIT PATH Street Outreach Supplemental Form

This form will allow Street Outreach projects to track required HMIS Date of Contact and Date of Engagement data elements. Track all contacts for the head of household and each additional adult in the household. A separate form should be included for each adult member of the household. Use additional forms as needed.

CLIENT (name or other identifier)

Program Exit Date

		/			/				
Month		Day		Year					

DESTINATION

Which of the following *most closely matches* where the client will be staying right after leaving this project?

- | | |
|---|---|
| <input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH |
| <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher | <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH |
| <input type="checkbox"/> Safe Haven | <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy |
| <input type="checkbox"/> Foster care home or foster care group home | <input type="checkbox"/> Rental by client, with VASH housing subsidy |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) |
| <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Rental by client, with VASH housing subsidy |
| <input type="checkbox"/> Substance abuse treatment facility or detox center | <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons |
| <input type="checkbox"/> Residential project or halfway house with no homeless criteria Hotel or motel paid for without emergency shelter voucher Owned by client, no ongoing housing subsidy | <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy |
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher | <input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based) |
| <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) | <input type="checkbox"/> Rental by client in a public housing unit |
| <input type="checkbox"/> Host Home (non-crisis) | <input type="checkbox"/> Rental by client, no ongoing housing subsidy |
| <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room apartment or house) | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy |
| <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) | <input type="checkbox"/> Owned by client, with ongoing housing subsidy |
| <input type="checkbox"/> Staying or living with friends, permanent tenure | <input type="checkbox"/> Owned by client, no ongoing housing subsidy |

Other Deceased

Client doesn't know

Data not collected

Client refused

No exit interview collected

Connection with SOAR

No

Yes

Client Doesn't Know

Client Refused

Data Not Collected

COMPLETE DATE OF STATUS DETERMINATION ONLY ONCE, WHEN THE ENROLLMENT STATUS FOR THE CLIENT HAS BEEN DETERMINED. THERE SHOULD ONLY BE ONE DATE OF STATUS DETERMINATION PER PROJECT STAY.

Date of Status Determination

		/			/				
Month			Day			Year			

Client Became Enrolled in PATH

Yes

No

If "No" to Reason Not Enrolled

Client was found ineligible for PATH

Client was not enrolled for other reason (s)

Unable to locate client

DISABLING CONDITIONS AND BARRIERS

DISABLING CONDITION

Record whether the client has a disabling condition based on one or more of the following:

- A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:
 1. Is expected to be long-continuing or of indefinite duration;
 2. Substantially impedes the individual's ability to live independently; and
 3. Could be improved by the provision of more suitable housing conditions.
- A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or
- The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

If the client is a veteran who is disabled by an injury or illness that was incurred or aggravated during active military service and whose disability meets the disability definition defined in Section 223 of the social security act, they should be identified as having a disabling condition.

Does the client currently have a disabling condition?

No

Yes

Client doesn't know

Client refused

Data not collected

[IF YES] Answer 'Yes' or 'No' for each condition.

PHYSICAL DISABILITY

Does the client currently have a physical disability?

No

Yes

Client doesn't know

Client refused

Data not collected



[IF YES for physical disability] Is the physical disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

No

Yes

Client doesn't know

Client refused

Data not collected

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused

Data not collected

CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

No

Yes

Client doesn't know

Client refused

Data not collected



[IF YES for chronic health condition] Is the physical disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

No

Yes

Client doesn't know

Client refused

Data not collected

HIV - AIDS

Does the client currently have HIV - AIDS?

No

Yes

Client doesn't know

Client refused

Data not collected

MENTAL HEALTH DISORDER

Does the client currently have a mental health disorder?

No

Yes

Client doesn't know

Client refused

Data not collected



[IF YES for mental health disorder] Is the mental health disorder expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

No

Yes

Client doesn't know

Client refused

Data not collected

SUBSTANCE ABUSE DISORDER

Does the client currently have a substance abuse disorder?

No

Alcohol abuse

Drug abuse

Both alcohol and drug abuse

Client doesn't know

Client refused



[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

No

Yes

Client doesn't know

Client refused

Data not collected

MONTHLY INCOME AND SOURCES

Only record regular, recurrent sources that are current as of today (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income).

Does the client have any income from any source?

No

Yes

Client doesn't know

Client refused

Data not collected



[IF YES] Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)			
Earned income (i.e., employment income)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Unemployment Insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Supplemental Security Income (SSI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Social Security Disability Insurance (SSDI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
VA Service-Connected Disability Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
VA Non-Service-Connected Disability Pension	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Private disability insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Worker's Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Temporary Assistance for Needy Families (TANF)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
General Assistance (GA)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Retirement Income from Social Security	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Pension or retirement income from a former job	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Child support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Alimony or other spousal support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Other source If yes, specify source: _____	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$. 0 0
Total monthly income from all sources			\$. 0 0

NON-CASH BENEFITS

Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.

Does the client have any non-cash benefits from any source?

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Data not collected



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP, CalFresh)
<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	TANF Child Care services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Other Non-Cash Benefit (source: _____)

HEALTH INSURANCE

Covered by Health Insurance?

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Data not collected



[IF YES] Answer 'Yes' or 'No' for each health insurance source.
Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Type of health insurance
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Other If Yes, specify source: _____

WELL-BEING

Client perceives their life has value and worth.

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Strongly agree
<input type="checkbox"/> Somewhat disagree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Neither agree nor disagree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Somewhat agree	<input type="checkbox"/> Data not collected

Client perceives they have support from others who will listen to problems.

<input type="checkbox"/> Strongly disagree	<input type="checkbox"/> Strongly agree
<input type="checkbox"/> Somewhat disagree	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Neither agree nor disagree	<input type="checkbox"/> Client refused
<input type="checkbox"/> Somewhat agree	<input type="checkbox"/> Data not collected

Client perceives they have a tendency to bounce back after hard times.

Strongly disagree

Somewhat disagree

Neither agree nor disagree

Somewhat agree

Strongly agree

Client doesn't know

Client refused

Data not collected

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 everyday

Client doesn't know

Client refused

Data not collected

GENERAL HEALTH STATUS

Excellent

Very good

Good

Fair

Poor

Client doesn't know

Client refused

Data not collected