

Agency Name: _____



CLARITY HMIS: HHS-PATH PROJECT EXIT FORM

Use block letters for text and bubble in the appropriate circles.

Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER: _____

PROJECT EXIT DATE *[All Clients]*

		/			/				
Month			Day			Year			

DESTINATION *[All Clients]*

<input type="radio"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside)	<input type="radio"/> Moved from one HOPWA funded project to HOPWA TH
<input type="radio"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter	<input type="radio"/> Staying or living with family, permanent tenure
<input type="radio"/> Safe Haven	<input type="radio"/> Staying or living with friends, permanent tenure
<input type="radio"/> Foster care home or foster care group home	<input type="radio"/> Moved from one HOPWA funded project to HOPWA PH
<input type="radio"/> Hospital or other residential non-psychiatric medical facility	<input type="radio"/> Rental by client, no ongoing housing subsidy
<input type="radio"/> Jail, prison or juvenile detention facility	<input type="radio"/> Rental by client, with ongoing housing subsidy
<input type="radio"/> Long-term care facility or nursing home	<input type="radio"/> Owned by client, with on-going housing subsidy
<input type="radio"/> Psychiatric hospital or other psychiatric facility	<input type="radio"/> Owned by client, no on-going housing subsidy
<input type="radio"/> Substance abuse treatment facility or detox center	<input type="radio"/> No exit interview completed
<input type="radio"/> Transitional housing for homeless persons (including homeless youth)	<input type="radio"/> Other
<input type="radio"/> Residential project or halfway house with no homeless criteria	<input type="radio"/> Deceased
<input type="radio"/> Hotel or motel paid for without emergency shelter voucher	<input type="radio"/> Client doesn't know
<input type="radio"/> Host Home (non-crisis)	<input type="radio"/> Client prefers not to answer
<input type="radio"/> Staying or living in a friend's room, apartment, or house	<input type="radio"/> Data not collected
<input type="radio"/> Staying or living in a family member's room, apartment or house	
IF "RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY" – SPECIFY:	
<input type="radio"/> GPD TIP housing subsidy	<input type="radio"/> Emergency Housing Voucher
<input type="radio"/> VASH Housing subsidy	<input type="radio"/> Family Unification Program Voucher (FUP)
<input type="radio"/> RRH or equivalent subsidy	<input type="radio"/> Foster Youth to Independence Initiative (FYI)
<input type="radio"/> HCV voucher (tenant or project based) (not dedicated)	<input type="radio"/> Permanent Supportive Housing
<input type="radio"/> Public Housing Unit	<input type="radio"/> Other permanent housing dedicated for formerly homeless persons
<input type="radio"/> Rental by client, with other ongoing housing subsidy	

CONNECTION WITH SOAR *[Head of Household and Adults]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

PATH STATUS *[If not at intake]*

Date of Status Determination	<input type="radio"/> ____/____/____
Client Became Enrolled in PATH	<input type="radio"/> No
	<input type="radio"/> Yes
IF "NO" TO ENROLLED IN PATH	
Reason Not Enrolled	<input type="radio"/> Client was found ineligible for PATH
	<input type="radio"/> Client was not enrolled for other reason(s)
	<input type="radio"/> Unable to locate client

PHYSICAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO PHYSICAL DISABILITY – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

HIV-AIDS *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer	
	<input type="radio"/> Data not collected	
IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know	
<input type="radio"/> Alcohol use disorder	<input type="radio"/> Client prefers not to answer	
<input type="radio"/> Drug use disorder	<input type="radio"/> Data not collected	
<input type="radio"/> Both alcohol and drug use disorders		
IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY		
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
		<input type="radio"/> Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know		
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer		
	<input type="radio"/> Data not collected		
IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY			
Income Source	Amount	Income Source	Amount
<input type="radio"/> Earned Income		<input type="radio"/> Temporary Assistance for Needy Families (TANF)	
<input type="radio"/> Unemployment Insurance		<input type="radio"/> General Assistance (GA)	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Retirement income from Social Security	
<input type="radio"/> Social Security Disability Insurance (SSDI)		<input type="radio"/> Pension or retirement income from a former job	
<input type="radio"/> VA Service-Connected Disability Compensation		<input type="radio"/> Child support	
<input type="radio"/> VA Non-Service-Connected Disability Pension		<input type="radio"/> Alimony and other spousal Support	
<input type="radio"/> Private Disability Insurance		<input type="radio"/> Other income source (<i>specify</i>):	
<input type="radio"/> Worker's Compensation			
Total Monthly Income for Individual:			

RECEIVING NON-CASH BENEFITS *[Head of Household and Adults]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY	
<input type="radio"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="radio"/> TANF Child Care Services
<input type="radio"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="radio"/> TANF Transportation Services
<input type="radio"/> Other (<i>specify</i>):	<input type="radio"/> Other TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client prefers not to answer
	<input type="radio"/> Data not collected
IF "YES" TO HEALTH INSURANCE – HEALTH INSURANCE COVERAGE DETAILS	
<input type="radio"/> MEDICAID	<input type="radio"/> Employer Provided Health Insurance
<input type="radio"/> MEDICARE	<input type="radio"/> Health Insurance Obtained Through COBRA
<input type="radio"/> State Children's Health Insurance (SCHIP)	<input type="radio"/> Private Pay Health Insurance
<input type="radio"/> Veteran's Health Administration (VHA)	<input type="radio"/> State Health Insurance for Adults
<input type="radio"/> Inland Empire Health Plan (IEHP)	<input type="radio"/> Molina Healthcare
<input type="radio"/> Kaiser Permanente	<input type="radio"/> Indian Health Services Program
<input type="radio"/> Other (specify):	<input type="radio"/>

CONTACT INFORMATION *[Optional – can be entered in Contact Tab]*

Contact Type										
Email										
Phone (#1)										
Phone (#2)										
Active Contact	<input type="radio"/>	Yes		<input type="radio"/>	No					
Private	<input type="radio"/>	Yes		<input type="radio"/>	No					
Contact Date										
Note										

CURRENT ADDRESS (IF APPLICABLE) *[Optional – can be entered in Location Tab]*

Street			
City			
Street		Zip Code	

Signature of applicant stating all information is true and correct Date