**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 DayYear**

DESTINATION *[All Clients]*

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

PATH STATUS*[If not at intake]*

|  |  |  |
| --- | --- | --- |
| **Date of Status Determination** | ○ | \_\_\_/\_\_\_\_\_\_/\_\_\_\_ |
| Client Became Enrolled in PATH | ○ | No |
| ○ | Yes |
| **IF “NO” TO ENROLLED IN PATH** | | |
| Reason Not Enrolled | ○ | Client was found ineligible for PATH |
| ○ | Client was not enrolled for other reason(s) |
| ○ | Unable to locate client |

PHYSICAL DISABILITY ​*[All Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

DEVELOPMENTAL DISABILITY ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

CHRONIC HEALTH CONDITION ​*[All Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

HIV-AIDS ​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |

MENTAL HEALTH DISORDER ​*[All Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
|  | | | | ○ | 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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

SUBSTANCE USE DISORDER ​*[All Clients]*

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| ○ | | No | | | ○ | Client doesn’t know |
| ○ | | Alcohol use disorder | | | ○ | Client prefers not to answer |
| ○ | Drug use disorder | | | | ○ | Data not collected |
| ○ | 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? | | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  |  | ○ | Data not collected |

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

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

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

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |
| **IF “YES” TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY** | | | |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Child Care Services |
| ○ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | ○ | TANF Transportation Services |
| ○ | Other (specify): | ○ | Other TANF-funded services |

COVERED BY HEALTH INSURANCE​*[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
|  | | ○ | Data not collected |
| **IF “YES” TO HEALTH INSURANCE** – **HEALTH INSURANCE COVERAGE DETAILS** | | | |
| ○ | MEDICAID | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE | ○ | Health Insurance Obtained Through COBRA |
| ○ | State Children’s Health Insurance (SCHIP) | ○ | Private Pay Health Insurance |
| ○ | Veteran’s Health Administration (VHA) | ○ | State Health Insurance for Adults |
| ○ | Other (specify): | ○ | Indian Health Services Program |

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

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Contact Type** |  | | | | | | | | | |
| **Email** |  | | | | | | | | | |
| **Phone (#1)** |  |  |  |  |  |  |  |  |  |  |
| **Phone (#2)** |  |  |  |  |  |  |  |  |  |  |
| **Active Contact** | ○ | Yes | | | | ○ | No | | | |
| **Private** | ○ | Yes | | | | ○ | 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**