

# Contra Costa HMIS Exit Form

Client Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_

Exit Date: \_\_\_\_\_  
 Program \_\_\_\_\_

## Exit Data

Please answer all questions on this form for each adult in the household. It is recommended to have the client's Intake form on hand when filling out this form. Income Sources and Disabilities that are on the Intake form and NOT indicated on this form will be assumed to have ended, and will be marked as "ended" in the HMIS.

### Reason for leaving:

- Left for a housing opportunity before completing program
- Completed program
- Non-payment of rent
- Non-compliance with program
- Criminal activity/violence
- Reached maximum time allowed
- Needs could not be met
- Disagreement with rules/persons
- Death
- Unknown/disappeared
- Other \_\_\_\_\_

### Housing Status at Exit:

- Category 1 - Homeless
- Category 2 - At imminent risk of losing housing (within 14 days)
- Category 3 - Homeless only under other federal statutes
- Category 4 - Fleeing domestic violence
- At-risk of homelessness
- Stably housed
- Client doesn't know
- Client refused

### Discharged to What City?

\_\_\_\_\_

### Destination:

- Place not meant for habitation (e.g., a vehicle, abandoned building, bus/train/subway station/airport or anywhere outside)
- Emergency shelter, including hotel or motel paid for with emergency shelter voucher
- Transitional housing for homeless persons (including homeless youth)
- Permanent housing for formerly homeless persons (such as CoC project; or HUD legacy programs; or HOPWA PH)
- Hotel or motel paid for without emergency shelter voucher
- Foster care home or foster care group home
- Psychiatric hospital or other psychiatric facility
- Hospital or other residential non-psychiatric medical facility
- Long-term care facility or nursing home
- Substance abuse treatment facility or detox center
- Jail, prison or juvenile detention facility
- Residential project or halfway house with no homeless criteria
- Moved from one HOPWA funded project to HOPWA PH
- Moved from one HOPWA funded project to HOPWA TH
- Owned by client, no ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Rental by client, no housing subsidy
- Rental by client, VASH Subsidy
- Rental by client, GPD TIP housing subsidy
- Rental by client, other (non- VASH) housing subsidy
- Staying or living with family, permanent tenure
- Staying or living with family, temporary tenure
- Staying or living with friends, permanent tenure
- Staying or living with friends, temporary tenure
- Other \_\_\_\_\_

### If moved into a permanent housing situation, Move-in Date?

\_\_\_\_/\_\_\_\_/\_\_\_\_

### Housing Assessment Disposition

- Referred to emergency shelter/safe haven
- Referred to transitional housing
- Referred to rapid re-housing
- Referred to permanent supportive housing
- Referred to homelessness prevention
- Referred to street outreach
- Referred to other continuum project type
- Referred to a homelessness diversion program
- Unable to refer/accept within continuum; ineligible for continuum projects
- Unable to refer/accept within continuum; continuum services unavailable
- Referred to other community project (non-continuum)
- Applicant declined referral/acceptance
- Applicant terminated assessment prior to completion
- Other \_\_\_\_\_
- N/A

### Are you employed? Yes / No If employed, type of employment?

- Full Time
  - Part Time
  - Seasonal
- Hours per week? \_\_\_\_\_  
 Where? \_\_\_\_\_

### If unemployed, why?

- Looking for work
- Unable to work
- Not looking for work
- Other \_\_\_\_\_

## Monthly Income

Received in Past 30 Days?		Received in Past 30 Days?	
\$ _____ Earned income (ie. employment income)	Yes / No	\$ _____ Alimony or other spousal support	Yes / No
\$ _____ Retirement income from Social Security	Yes / No	\$ _____ SSI	Yes / No
\$ _____ Pension from a former job (including military retirement pay)	Yes / No	\$ _____ SSDI	Yes / No
\$ _____ Private disability insurance	Yes / No	\$ _____ General Assistance	Yes / No
\$ _____ Child support	Yes / No	\$ _____ TANF	Yes / No
\$ _____ Unemployment insurance	Yes / No	\$ _____ Other Income Source: _____	
\$ _____ Worker's compensation	Yes / No	<input type="checkbox"/> No Financial Resources	
\$ _____ VA service-connected disability compensation	Yes / No		
\$ _____ VA non service-connected disability pension	Yes / No		
<b>Total Monthly Income: \$ _____ (please indicate if \$0)</b>			

### Non Cash Benefits

Received in Past 30 Days?	
- Supplemental Nutrition Assistance Program (Food stamps)	Yes / No
- TANF Child Care Services	Yes / No
- TANF Transportation Services	Yes / No
- Other TANF-funded services	Yes / No
- WIC	Yes / No
- Section 8, public housing, or other ongoing rental assistance	Yes / No
- Temporary rental assistance	Yes / No
- Other _____	Yes / No

### Health Insurance

Currently covered?		*HOPWA: If no, reason?	
- Medicaid/Medi-Cal	Yes / No		_____
- MEDICARE	Yes / No		_____
- State Children's Health Insurance Program (SCHIP)	Yes / No		_____
- Veteran's Administration (VA) Medical Services	Yes / No		_____
- Employer-provided Health Insurance	Yes / No		_____
- Health insurance obtained through COBRA	Yes / No		_____
- Private Pay Health Insurance	Yes / No		_____
- State Health Insurance for Adults	Yes / No		_____
- Indian Health Services Program	Yes / No		_____

**\*HOPWA Only: If not covered, indicate reason (A= Applied but decision pending, B = Applied but client was ineligible, C = Client did not apply, D = Insurance Type not applicable).**

## Disabilities

Yes/No	Severity Documented?	Long Term?	Receiving Aid?	Yes/No	Severity Documented?	Long Term?	Receiving Aid?	Yes/No	Severity Documented?	Long Term?	Receiving Aid?
1. Mental Health Problem	_____	_____	_____	4. HIV/AIDS	_____	_____	_____	7. Chronic Health Condition	_____	_____	_____
2. Alcohol Abuse	_____	_____	_____	5. Physical	_____	_____	_____	8. Other: _____	_____	_____	_____
3. Drug Abuse	_____	_____	_____	6. Developmental	_____	_____	_____		_____	_____	_____

Note: Chronic health condition – a diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples include but are not limited to: heart disease, severe asthma, diabetes, arthritis-related conditions, adult onset cognitive impairments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions), severe headache/migraine, cancer, chronic bronchitis, liver condition, stroke, or emphysema.

**PATH only:** If answered Yes to Mental Health above, is it a Serious Mental Illness (SMI)? \_\_\_\_\_

If answered Yes to Mental Health, Alcohol Abuse, or Drug Abuse above, indicate underneath each item how this was confirmed (CC = Confirmed thru clinical evaluation or assessment, CP = Confirmed by prior evaluation or clinic records, or U = Unconfirmed/Presumptive/Self Report).

**For Prevention Programs****Housing Assessment at Exit:**

- Able to maintain the housing they had at project entry
- Moved to new housing unit
- Moved in with family/friends on a temporary basis
- Moved in with family/friends on a permanent basis
- Moved to a transitional or temporary housing facility /program
- Client became homeless- moving to a shelter or other place unfit for human habitation
- Client went to jail/prison
- Client died

**If answered "able to maintain the housing they had at entry" above, subsidy type:**

- Without subsidy
- With the subsidy they had at project entry
- With an ongoing subsidy acquired after project entry
- Only with financial assistance other than a subsidy

**If answered "moved to new housing unit" above, subsidy type:**

- With an ongoing subsidy
- Without an ongoing subsidy

**For PATH Programs**

Date of PATH Status Determination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Client became enrolled in PATH? Yes / No

**If no, reason not enrolled?**

- Ineligible for PATH
- Other reasons

Connection with SOAR? Yes / No

**For HOPWA Programs**

Receiving Public HIV/AIDS Medical Assistance? Yes / No

**If no, reason?**

- |   |   |
|---|---|
| <input type="checkbox"/> Applied; decision pending    | <input type="checkbox"/> Insurance type N/A for this client |
| <input type="checkbox"/> Applied; client not eligible | <input type="checkbox"/> Client doesn't know                |
| <input type="checkbox"/> Client did not apply         | <input type="checkbox"/> Client refused                     |

Receiving AIDS Drug Assistance Program (ADAP)? Yes / No

**If no, reason?**

- |   |   |
|---|---|
| <input type="checkbox"/> Applied; decision pending    | <input type="checkbox"/> Insurance type N/A for this client |
| <input type="checkbox"/> Applied; client not eligible | <input type="checkbox"/> Client doesn't know                |
| <input type="checkbox"/> Client did not apply         | <input type="checkbox"/> Client refused                     |