

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			

CLIENT LOCATION *[only if multiple CoC's]* _____

DESTINATION *[-All Clients]*

<input type="radio"/>	Deceased	<input type="radio"/>	Rental by client, with RRH or equivalent subsidy
<input type="radio"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="radio"/>	Rental by client, with VASH housing subsidy
<input type="radio"/>	Foster care home or foster care group home	<input type="radio"/>	Rental by client, with GPD TIP housing subsidy
<input type="radio"/>	Hospital or other residential non--psychiatric medical facility	<input type="radio"/>	Rental by client, with other ongoing housing subsidy
<input type="radio"/>	Hotel or motel paid for without emergency shelter voucher	<input type="radio"/>	Residential project or halfway house with no homeless criteria
<input type="radio"/>	Jail, prison or juvenile detention facility	<input type="radio"/>	Safe Haven
<input type="radio"/>	Long-term care facility or nursing home	<input type="radio"/>	Staying or living with family, permanent tenure
<input type="radio"/>	Moved from one HOPWA funded project to HOPWA PH	<input type="radio"/>	Staying or living with family, temporary tenure (e.g., room, apartment or house)
<input type="radio"/>	Moved from one HOPWA funded project to HOPWA TH	<input type="radio"/>	Staying or living with friends, permanent tenure
<input type="radio"/>	Owned by client, no ongoing housing subsidy	<input type="radio"/>	Staying or living with friends, temporary tenure (e.g., room, apartment or house)
<input type="radio"/>	Owned by client, with ongoing housing subsidy	<input type="radio"/>	Substance abuse treatment facility or detox center
<input type="radio"/>	Permanent housing (other than RRH) for formerly homeless persons	<input type="radio"/>	Transitional housing for homeless persons (including homeless youth)
<input type="radio"/>	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/airport or anywhere outside)	<input type="radio"/>	Other (specify):
<input type="radio"/>		<input type="radio"/>	No exit interview completed
<input type="radio"/>	Psychiatric hospital or other psychiatric facility	<input type="radio"/>	Client doesn't know
<input type="radio"/>		<input type="radio"/>	Client refused
<input type="radio"/>	Rental by client, no ongoing housing subsidy	<input type="radio"/>	Data not collected

PATH STATUS *[If not at intake]*

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

CONNECTION WITH SOAR *[Heads of Households and Adults]*

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

DISABLING CONDITION *[All Clients – if 'yes' to any condition, mark 'yes']*

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

PHYSICAL DISABILITY *[All Clients]*

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

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Expected to substantially impair ability to live independently?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<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 refused
		<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 refused
			<input type="radio"/>	Data not collected

MENTAL HEALTH PROBLEM *[All Clients]*

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

IF "YES" TO MENTAL HEALTH PROBLEMS – 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 refused
			<input type="radio"/>	Data not collected

SUBSTANCE ABUSE PROBLEM *[All Clients]*

<input type="radio"/>	No	<input type="radio"/>	Both alcohol & drug abuse	
<input type="radio"/>	Alcohol abuse	<input type="radio"/>	Client doesn't know	
<input type="radio"/>	Drug abuse	<input type="radio"/>	Client refused	
		<input type="radio"/>	Data not collected	
IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – 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 refused
			<input type="radio"/>	Data not collected

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

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<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"/>	Alimony and Other Spousal Support	<input type="radio"/>	Child support
<input type="radio"/>	Pension or Retirement income from former job	<input type="radio"/>	Earned Income
<input type="radio"/>	Retirement Income from Social Security	<input type="radio"/>	General Assistance (GA)
<input type="radio"/>	Social Security Disability Insurance (SSDI)	<input type="radio"/>	Private Disability Insurance
<input type="radio"/>	Supplemental Security Income (SSI)	<input type="radio"/>	Unemployment Insurance
<input type="radio"/>	TANF (Temporary Assist for Needy Families)	<input type="radio"/>	Worker's Compensation
<input type="radio"/>	VA Service Connected Disability Compensation	<input type="radio"/>	Other source
<input type="radio"/>	VA Non--Service Connected Disability Pension	Other (specify):	
Total monthly amount:			

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 refused
		<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 Childcare Services
<input type="radio"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="radio"/>	TANF Transportation Services
<input type="radio"/>	Other (specify):	<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 refused
		<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"/>	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 Administration (VA) Medical Services	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other (specify):	<input type="radio"/>	Indian Health Services Program

CONTACT INFORMATION *[Optional- can be entered in Location Tab]*

Phone Number					-					-				
Email														
Current Address (if applicable)														
Street														
City														
State									Zip Code					

Signature of applicant stating all information is true and correct Date