**CLARITY HMIS: HUD-HOPWA 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/airport or anywhere outside) | ○ | Moved from one HOPWA funded project to HOPWA PH |
| --- | --- | --- | --- |
| ○ | Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY- funded Host Home Shelter | ○ | Moved from one HOPWA funded project to HOPWA TH |
| ○ | Safe Haven  | ○ | Rental by client, with GPD TIP housing subsidy  |
| ○ | Foster care home or foster care group home | ○ | Rental by client, with VASH housing subsidy |
| ○ | Hospital or other residential non­-psychiatric medical facility | ○ | Permanent housing (other than RRH) for formerly homeless persons |
| ○ | Jail, prison, or juvenile detention facility | ○ | Rental by client, with RRH or equivalent subsidy |
| ○ | Long-term care facility or nursing home | ○ | Rental by client with HCV voucher (tenant or project based) |
| ○ | Psychiatric hospital or other psychiatric facility | ○ | Rental by client in a public housing unit  |
| ○ | Substance abuse treatment facility or detox center | ○ | Rental by client, no ongoing housing subsidy |
| ○ | Residential project or hallway house with no homeless criteria  | ○ | Rental by client, with other ongoing housing subsidy |
| ○ | Hotel or motel paid for without emergency shelter voucher | ○ | Owned by client, with ongoing housing subsidy  |
| ○ | Transitional housing for homeless persons (including homeless youth) | ○ | Owned by client, noongoing housing subsidy |
| ○ | Host Home (non-crisis) | ○ |  No exit interview completed |
| ○ | Staying or living with friends, temporary tenure (e.g., room, apartment, or house) | ○ | Other (specify): |
| ○ | Staying or living with family, temporary tenure (e.g., room, apartment, or house) | ○ | Deceased |
| ○ | Client doesn’t know  |
| ○ | Staying or living with family, permanent tenure | ○ | Client refused  |
| ○ | Staying or living with friends, permanent tenure | ○ | Data not collected |

# **HOUSING ASSESSMENT AT EXIT** ​[­All Clients]

| ○ | Able to maintain the housing they had at project entry  | ○ | Client became homeless – moving to a shelter or other place unfit for human habitation |
| --- | --- | --- | --- |
| ○ | Moved to new housing unit  |
| ○ | Moved in with family/friends on a temporary basis  | ○ | Client went to jail/prison  |
| ○ | Client died  |
| ○ | Moved in with family/friends on a permanent basis  | ○ | Client doesn’t know  |
| ○ | Client refused  |
| ○ | Moved to a transitional or temporary housing facility or program  | ○ | Data not collected  |
| **IF “ABLE TO MAINTAIN HOUSING AT PROJECT ENTRY” TO HOUSING ASSESSMENT**  |
| **Subsidy Information**  |
| ○ | Without a subsidy  | ○ | With an on­going subsidy acquired since project entry  |
| ○ | With the subsidy they had at project entry  | ○ | Only with financial assistance other than a subsidy  |
| **IF “MOVED TO NEW HOUSING UNIT” TO HOUSING ASSESSMENT**  |
| **Subsidy Information**  |
| ○ | With on­going subsidy  | ○ | Without an on­going subsidy  |

**PHYSICAL DISABILITY** ​*[All Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “YES” TO PHYSICAL DISABILITY – SPECIFY**   |
| Expected to be of long-continued and indefinite duration? | ○ | No  | ○ | Client doesn’t know  |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**DEVELOPMENTAL DISABILITY** ​*[All Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**CHRONIC HEALTH CONDITION** ​*[All Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “YES” TO CHRONIC HEALTH CONDITION – SPECIFY**   |
| Expected to be of long-continued and indefinite duration? | ○ | No  | ○ | Client doesn’t know  |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**HIV-AIDS** *[All Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**MENTAL HEALTH DISORDER** ​*[All Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “YES” TO MENTAL HEALTH DISORDER– SPECIFY**   |
| Expected to be of long-continued and indefinite duration? | ○ | No  | ○ | Client doesn’t know  |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**SUBSTANCE USE DISORDER** ​*[All Clients]*

| ○ | No  | ○ | Both alcohol and drug use disorders  |
| --- | --- | --- | --- |
| ○ | Alcohol use disorder | ○ | Client doesn’t know  |
| ○ | Client refused  |
| ○ | Drug use disorder | ○ | Data not collected  |
| **IF “ALCOHOL USE DISORDER” “DRUG USE DISORDER” OR “BOTH ALCOHOL AND DRUG USE DISORDERS” – SPECIFY**  |
| Expected to be of long-continued and indefinite duration? | ○ | No | ○ | Client doesn’t know  |
| ○ | Yes | ○ | Client refused  |
| ○ | Data not collected  |

# **MONTHLY INCOME AND SOURCES** ​[Head of Household and Adults]

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “YES” TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY**  |
| **Income Source** | **Amount** | **Income Source** | **Amount** |
| ○ | Earned Income |  | ○ | TANF (Temporary Assist for Needy Families) |   |
| ○ | Unemployment Insurance |  | ○ | General Assistance (GA) |   |
| ○ | Supplemental Security Income (SSI)  |  | ○ | Retirement Income from Social Security |   |
| ○ | Social Security Disability Insurance (SSDI) |  | ○ | Pension or retirement income from 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 |   |
| ○ | Worker’s Compensation |  |  *(specify):* |
| **Total monthly income for Individual:**  |   |

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

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “YES” TO NON­CASH 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 refused  |
| ○ | Data not collected  |
| **IF “YES” TO HEALTH INSURANCE & REASONS NOT COVERED BY** NON-CHOSEN SELECTION(S)  |
| ○ | MEDICAID  | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | MEDICARE  | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | State Children’s Health Insurance (SCHIP)  | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Veterans Administration (VA) Medical Services | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Employer Provided Health Insurance | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Health Insurance Obtained through COBRA | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Private Pay Health Insurance | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | State Health for Adults | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Indian Health Services Program | ○ | Applied; Decision Pending |
| ○ | Applied; Client Not Eligible |
| ○ | Client Did Not Apply |
| ○ | Insurance Type N/A for this Client |
| ○ | Client Doesn’t Know |
| ○ | Client Refused |
| ○ | Data Not Collected |
| ○ | Other Health Insurance **(specify)** |  |

**IF “YES” TO HIV-AIDS:**

**Receiving Public HIV/AIDS Medical Assistance**

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “NO” TO RECEIVING PUBLIC HIV/AIDS MEDICAL ASSISTANCE** — **SPECIFY REASON** |
| ○ | Applied; Decision Pending | ○ | Client Doesn’t Know |
| ○ | Applied; Client Not Eligible | ○ | Client Refused |
| ○ | Client Did Not Apply | ○ | Data Not Collected |
| ○ | Insurance Type N/A for this Client |  |

**Receiving AIDS Drug Assistance Program (ADAP)**

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “NO” TO RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP)** — **SPECIFY REASON** |
| ○ | Applied; Decision Pending | ○ | Client Doesn’t Know |
| ○ | Applied; Client Not Eligible | ○ | Client Refused |
| ○ | Client Did Not Apply | ○ | Data Not Collected |
| ○ | Insurance Type N/A for this Client |  |

**Receiving Ryan White-funded Medical or Dental Assistance**

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |
| **IF “NO” TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE** — **SPECIFY REASON** |
| ○ | Applied; Decision Pending | ○ | Client Doesn’t Know |
| ○ | Applied; Client Not Eligible | ○ | Client Refused |
| ○ | Client Did Not Apply | ○ | Data Not Collected |
| ○ | Insurance Type N/A for this Client |  |

**T-cell (CD4) Count Available**

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

**T-cell Count (Integer between 0-1500): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How Was the Information Obtained?**

| ○ | Medical Report  |
| --- | --- |
| ○ | Client Reported  |
| ○ | Other (specify) |

**Viral Load Available**

| ○ | Available | ○ | Not Available |
| --- | --- | --- | --- |
| ○ | Undetectable | ○ | Client Doesn’t Know |
| ○ | Client Refused | ○ | Data Not Collected |

**Viral Load (Integer between 0-999999): \_\_\_\_\_\_\_\_\_\_\_**

**How Was the Information Obtained?**

| ○ | Medical Report  |
| --- | --- |
| ○ | Client Reported  |
| ○ | Other (specify) |

**Has the participant been prescribed anti-retroviral drugs?**

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client refused  |
| ○ | Data not collected  |

# **IN PERMANENT HOUSING** ​[Permanent Housing Projects, for Heads of Households]

| ○ | No | ○ | Yes |
| --- | --- | --- | --- |
| **IF “YES” TO PERMANENT HOUSING** |
| Housing Move-in Date (see note\*) | *\*If a client moved into permanent housing, make sure to update on the enrollment screen.*  |

**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**