**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/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 |

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

| ○ | No | ○ | Client doesn’t know |
| --- | --- | --- | --- |
| ○ | Yes | ○ | Client refused |
| ○ | 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 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 Households 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 ­ HEALTH INSURANCE COVERAGE DETAILS** | | | | | |
| ○ | MEDICAID | ○ | Employer Provided Health Insurance | | |
| ○ | MEDICARE | ○ | Insurance Obtained through COBRA | | |
| ○ | State Children’s Health Insurance (SCHIP) | ○ | Private Pay Health Insurance | | |
| ○ | Veterans Administration (VA) Medical Services | ○ | State Health Insurance for Adults | | |
| ○ | Other (specify): | ○ | 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**