

# HMIS Data Collection Template for Project EXIT – CoC Program

This form can be used by all CoC-funded project types: Street Outreach, Safe Haven, Transitional Housing, Rapid Re-housing, and Permanent Supportive Housing. Some project types are also required to track other information such as contacts, engagement, or move-in date. See [supplemental forms](#) for Prevention, Rapid Re-housing, Permanent Supportive Housing, and Street Outreach projects.

## FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN “X”

The form is broken into two sections for *All Clients* and *Head of Household and Other Adults in the Household* in order to eliminate duplication of data gathering when characteristics only apply to certain members of households.

## DATA FOR ALL CLIENTS

Respond to the following questions for all household members—each adult and child. A separate form should be included for each household member. Each household member may have separate exit dates, destinations, etc.

### PROJECT EXIT DATE (e.g., 08/24/2017)

The Project Exit Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day			Year			

**CLIENT** (name or other identifier)

Indicate here if no exit interview was completed:

## DESTINATION

Which of the following most closely matches where the client will be staying right after leaving this project?

Homeless Situations	<input type="checkbox"/> Place not meant for habitation	Continuum PH	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
	<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher		<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons
	<input type="checkbox"/> Safe Haven		<input type="checkbox"/> (not applicable for CoC-funded projects) To HOPWA PH from a HOPWA project
	<input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) (not applicable for CoC-funded projects) To HOPWA TH from a HOPWA project		
Non-Homeless	<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	Rent/Own with Subsidy	<input type="checkbox"/> Rental by client, with GPD TIP housing subsidy
	<input type="checkbox"/> Residential project or halfway house with no homeless criteria		<input type="checkbox"/> Rental by client, with VASH housing subsidy
	<input type="checkbox"/> Staying or living with family, temporary tenure (room, apartment, or house)		<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
	<input type="checkbox"/> Staying or living with friends, temporary tenure (room, apartment, or house)		<input type="checkbox"/> Owned by client, with ongoing housing subsidy
Institutional Situations	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	Rent/Own no Subsidy	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
	<input type="checkbox"/> Substance abuse treatment facility or detox center		<input type="checkbox"/> Owned by client, no ongoing housing subsidy
	<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	Other Permanent	<input type="checkbox"/> Staying or living with family, permanent tenure
	<input type="checkbox"/> Jail, prison, or juvenile detention facility		<input type="checkbox"/> Staying or living with friends, permanent tenure
	<input type="checkbox"/> Foster care home or foster care group home	Other	<input type="checkbox"/> Deceased
	<input type="checkbox"/> Long-term care facility or nursing home		<input type="checkbox"/> Other
			<input type="checkbox"/> Client doesn't know
			<input type="checkbox"/> Client refused

## DATA FOR ALL CLIENTS (CONTINUED)

### PHYSICAL DISABILITY

Does the client currently have a physical disability?

No

Yes

Client doesn't know

Client refused



**[IF YES] Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

### DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused



**[IF YES] Is the developmental disability expected to substantially impair the client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

### CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

No

Yes

Client doesn't know

Client refused



**[IF YES] Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

### HIV/AIDS

Does the client currently have HIV/AIDS?

No

Yes

Client doesn't know

Client refused



**[IF YES] Is HIV/AIDS expected to substantially impair the client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

## DATA FOR ALL CLIENTS (CONTINUED)

### MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

No

Yes

Client doesn't know

Client refused



**[IF YES] Is the mental health problem expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

### SUBSTANCE ABUSE PROBLEM

Does the client currently have a substance abuse problem?

No

Alcohol abuse

Drug abuse

Both alcohol and drug abuse

Client doesn't know

Client refused



**[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse] Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?**

No

Yes

Client doesn't know

Client refused

### HEALTH INSURANCE

Is the client currently covered by health insurance?

No

Yes

Client doesn't know

Client refused



**[IF YES] Answer 'Yes' or 'No' for each health insurance source.**

Answer 'No' for sources that have been terminated, even if they were received in the past.

No	Yes	Source
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Other If Yes, specify source: _____



## DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Respond to the following questions for the head of household and each additional adult in the household. If the household is composed of an unaccompanied child, that child is the head of household. If the household is composed of two or more minors, data must be collected about the minor that has been designated as the head of household. A separate form should be included for each adult member of the household.

### NON-CASH BENEFITS

#### Does the client have any non-cash benefits from any source?

Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.

No

Client doesn't know

Yes

Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source.

Source of income	Receiving Benefits from source?	
Supplemental Nutrition Assistance Program (SNAP)	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
TANF Child Care services (or use local name)	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
TANF transportation services (or use local name)	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
Other TANF-Funded Services (or use local name)	No	<input type="checkbox"/>
	Yes	<input type="checkbox"/>
Other source	No	<input type="checkbox"/>
If yes, specify source: _____	Yes	<input type="checkbox"/>

**INCOME AND SOURCES**

Only record regular, recurrent sources that are current as of today (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income).

Does the client have any income from any source?

No

Yes

Client doesn't know

Client refused



**[IF YES] Answer Yes or No for each income source.**

If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate. Answer 'No' for sources that have been terminated, even if they were received in the past.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)			
Earned income (i.e., employment income)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Unemployment Insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Supplemental Security Income (SSI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Social Security Disability Insurance (SSDI)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
VA Service-Connected Disability Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
VA Non-Service-Connected Disability Pension	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Private disability insurance	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Worker's Compensation	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Temporary Assistance for Needy Families (TANF)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
General Assistance (GA)	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Retirement Income from Social Security	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Pension or retirement income from a former job	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Child support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Alimony or other spousal support	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
Other source If yes, specify source: _____	No	<input type="checkbox"/>			
	Yes	<input type="checkbox"/>	\$		. 0 0
<b>Total monthly income from all sources</b>			\$		. 0 0

