

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, 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.

PROJECT EXIT DATE (e.g., 08/24/2014)

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)

DESTINATION

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

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

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

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 of non-cash benefit
<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 _____

PHYSICAL DISABILITY

Does the client currently have a physical disability?

No

Yes

Client doesn't know

Client refused



[IF YES for physical disability] 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

[IF YES for physical disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for physical disability] Is the client currently receiving services/treatment for this disability?

No

Client doesn't know

Yes

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

No

Yes

Client doesn't know

Client refused



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

No

Yes

Client doesn't know

Client refused

[IF YES for developmental disability] Is documentation of the disability and severity on file?

No

Yes

[IF YES for developmental disability] Is the client currently receiving services/treatment for this disability?

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 for chronic health condition] 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

[IF YES for chronic health condition] Is documentation of the disability and severity on file?

No

Yes

[IF YES for chronic health condition] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

HIV/AIDS

Does the client currently have HIV/AIDS?

No

Yes

Client doesn't know

Client refused



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

No

Yes

Client doesn't know

Client refused

[IF YES for HIV/AIDS] Is documentation of the disability and severity on file?

No

Yes

[IF YES for HIV/AIDS] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

MENTAL HEALTH PROBLEM

Does the client currently have a mental health problem?

No

Yes

Client doesn't know

Client refused



[IF YES for mental health problem] 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

[IF YES for mental health problem] Is documentation of the disability and severity on file?

No

Yes

[IF YES for mental health problem] Is the client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

DATA FOR ALL CLIENTS (CONTINUED)

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 for substance abuse problem] 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

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is documentation of the disability and severity on file?

No

Yes

[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse for substance abuse problem] Is client currently receiving services/treatment for this condition?

No

Yes

Client doesn't know

Client refused

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.

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.

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 Income (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	No	<input type="checkbox"/>			

If yes, specify source: _____	Yes	<input type="checkbox"/>	\$. 0 0
Total monthly income from all sources			\$. 0 0

DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS (CONTINUED)

NON-CASH BENEFITS

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.

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

<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes	<input type="checkbox"/> Client refused



[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)

No	Yes	Source of non-cash benefit
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP)
<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	TANF Child Care services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services <i>(or use local name)</i>
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, Public Housing, or other ongoing rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance
<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____