

# HMIS Universal Exit/Update Form - Adults

Completed By: \_\_\_\_\_ Program: \_\_\_\_\_ Clarity ID #: \_\_\_\_\_

Update

Annual Review

Exit

Client Name: \_\_\_\_\_

Update/Exit Date:

		/			/				
month			day			year			

## Reason for Leaving (Exit Only)

- |   |  |
|---|--|
| <input type="checkbox"/> Completed Program                                      | <input type="checkbox"/> Reached maximum time allowed by program |
| <input type="checkbox"/> Left for housing opportunity before completing program | <input type="checkbox"/> Needs could not be met by program       |
| <input type="checkbox"/> Non-payment of rent/occupancy charge                   | <input type="checkbox"/> Disagreement with rules/persons         |
| <input type="checkbox"/> Non-compliance with program                            | <input type="checkbox"/> Death                                   |
| <input type="checkbox"/> Criminal activity/destruction of property/violence     | <input type="checkbox"/> Unknown/disappeared                     |
| <input type="checkbox"/> Other: _____   |  |

## Exit Destination (Exit Only)

### Homeless Situation:

- |   |  |
|---|--|
| <input type="checkbox"/> Place not meant for habitation | <input type="checkbox"/> Emergency Shelter |
| <input type="checkbox"/> Safe Haven                     |  |

### Institutional Situation:

- |   |   |
|---|---|
| <input type="checkbox"/> Foster care home or foster care group home         | <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility |
| <input type="checkbox"/> Jail, prison, or juvenile detention facility       | <input type="checkbox"/> Long-term care facility or nursing home                        |
| <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Substance abuse treatment facility or detox center             |

### Transitional and Permanent Housing Situation:

- |  |   |
|--|---|
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher   | <input type="checkbox"/> Owned by client, no ongoing housing subsidy                    |
| <input type="checkbox"/> Owned by client, with ongoing housing subsidy               | <input type="checkbox"/> PH (other than RRH) for formerly homeless persons              |
| <input type="checkbox"/> Rental by client with HCV voucher (tenant or project based) | <input type="checkbox"/> Rental by client, with VASH subsidy                            |
| <input type="checkbox"/> Rental by client, with GPD TIP subsidy                      | <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy               |
| <input type="checkbox"/> Rental by client, no ongoing housing subsidy                | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy           |
| <input type="checkbox"/> Rental by client in a public housing unit                   | <input type="checkbox"/> Transitional Housing for homeless persons                      |
| <input type="checkbox"/> Staying or living in a friends, temporary tenure            | <input type="checkbox"/> Staying or living in a family, temporary tenure                |
| <input type="checkbox"/> Staying or living in a friends, permanent tenure            | <input type="checkbox"/> Staying or living in a family, permanent tenure                |
| <input type="checkbox"/> Host Home (non-crisis)                                      | <input type="checkbox"/> Residential project or halfway house with no homeless criteria |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH             | <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH                |
| <input type="checkbox"/> No Exit Interview Completed                                 | <input type="checkbox"/> Deceased   |
| <input type="checkbox"/> Client Doesn't Know   | <input type="checkbox"/> Client refused   |

Exit Address: \_\_\_\_\_

## Disabling Conditions (all clients)

### Physical

#### Long term?

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

### Developmental

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

### Chronic Health

#### Long term?

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

### HIV

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

### Mental Health

#### Long term?

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

### Alcohol Use Disorder

#### Long term?

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

### Drug Abuse

#### Long term?

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

### Both Alcohol/Drug

#### Long term?

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

## Domestic Violence (HoH & Adults)

Is client a domestic violence victim/survivor?

No  Yes

Client doesn't know

Client refused

If Yes, when did the experience occur?

Within the past three months

Three to six months ago

Six months to one year ago

One year or more

If yes, are you currently fleeing?

No  Client doesn't know

Client doesn't know

Yes  Client refused

Client refused

## Income

Income from Any Source (HoH & Adults (child-->HoH))

No  Yes

Client doesn't know  Client refused

Answer Yes or No for each income source (status at time of entry)

Source of Income	Receiving income?	If yes, monthly amount from source (round down to nearest dollar)	
Earned income (i.e., employment income)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Unemployment Insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Supplemental Security Income (SSI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Social Security Disability Income (SSDI)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
VA Service-Connected Disability	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
VA Non-Service-Connected Disability Pension	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Private disability insurance	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Worker's Compensation	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
General Assistance (GA)	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Retirement Income from Social Security	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Pension or retirement income from a former job	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Child support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Alimony or other spousal support	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
Other Source	<input type="checkbox"/> No <input type="checkbox"/> Yes	\$	.00
If yes, specify source:		\$	.00
<b>Total Monthly Income from all sources</b>		<b>\$</b>	<b>.00</b>

## Non-Cash Benefits

Non-Cash Benefits from any source? (HoH & Adults (children go on HoH))

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p><b>Answer 'Yes' or 'No' for each non-cash benefit source (Based on the status at the time of entry)</b></p> <p><b>No    Yes    Source of non-cash benefit</b></p> <table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Special Supplemental Nutrition Assistance Program (SNAP)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>TANF Child Care services</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>TANF transportation services</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other TANF-Funded Services</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other source: _____</td> </tr> </table>	<input type="checkbox"/>	<input type="checkbox"/>	Special 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	<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services	<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services																	
<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____																	

## Health Insurance

Covered by health insurance (all clients)

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<p><b>Answer 'Yes' or 'No' for each health insurance source. (Based on the status at the time of entry)</b></p> <p><b>No    Yes    Source of insurance coverage</b></p> <table border="1"> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Medicaid</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Medicare</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>State Children's Health Insurance Program</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Veteran's Administration (VA) Medical Services</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Employer-Provided Health Insurance</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Health insurance obtained through COBRA</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Private Pay Health Insurance</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>State Health Insurance for Adults (or use local name)</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Indian Health Services Program</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Other source: _____</td> </tr> </table>	<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	<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 source: _____
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<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program																													
<input type="checkbox"/>	<input type="checkbox"/>	Other source: _____																													

## For Permanent Destinations:

Housing Move-In Date:  /  /   
month                      day                      year

Monthly Rent & Utilities Combined (estimated): \_\_\_\_\_