

MO-604 HMIS Exit form

Instructions: Please use this form to enter all information into CaseWorthy. Know that this form can be edited to fit your specific program needs.

Project Start Date: _____ **Move in Date:** _____ **Project Exit Date:** _____

Client ID number: _____ **Family ID number:** _____ **Relationship to HOH:** _____

First Name: _____ **Last Name:** _____

Middle Name: _____ **Suffix:** _____

Date of Birth: ____/____/____ **Deceased Date:** ____/____/____

Social Security Number: _____-_____-_____

Gender: Male Female Transgender Questioning A Gender that is not singularly (male/female) Client Doesn't Know

Citizenship: Eligible Non-Citizen Ineligible Non-Citizen U.S. Citizen Undocumented

Primary Language: Chinese Spanish English Bilingual- English/Spanish Russian Arabic

Race: White Black or African American Asian American Indian or Alaska Native Native Hawaiian/ Pacific Islander Client Doesn't Know Client Refused Data Not Collected

Ethnicity: Non-Hispanic/Non-Latin (a,o,x) Hispanic or Latin (a,o,x) Client Doesn't Know Client Refused Data Not Collected

Veteran Status: Yes No Client doesn't know Client refused Data Not Collected

Address: _____ **Apt. Number:** _____

Zip Code: _____ **City:** _____ **State:** _____ **County:** _____

Cell Phone: _____ **Home Phone:** _____

Work Phone: _____ **Email:** _____

Sharing: Client should be marked as shared. Not shared will cause all the client's information to not be visible to any org

UNIVERSAL ASSESSMENT: This assessment at exit will be blank please proceed to Program assessment.

PROGRAM ASSESSMENT

Destination Type:

Homeless Situation

Emergency Shelter including hotel-motel paid for with ES voucher or RHY Funded Host Home Shelter Place not meant for human habitation Safe Haven

Institutional Situation

Foster care or foster care group home Hospital or other residential non-psychiatric medical facility Jail, prison, or juvenile detention facility
Long-term care facility or Nursing Home Psychiatric Hospital or other psychiatric facility Substance Abuse treatment facility or detox center

Transitional & Permanent Housing Situation

Hotel-motel paid without ES voucher Rented or owned by client, no ongoing housing subsidy Rented or owned ongoing housing subsidy
Permanent housing (other than RRH) Staying or living with family Transitional Housing for homeless person
Rental by client with GPD TID housing subsidy Residential project or halfway house with no Homeless criteria Host Home (non-crisis)
Rental by client with RRH or equivalent subsidy Rental by client with HCV Voucher Rental by client in a public housing unit
Client doesn't know Client refused Data Not Collected

Other Situation

Deceased No Exit Interview Completed Client Doesn't Know Client Refused Data not Collected

Other (Specify): _____

Non-cash benefit from any source? Yes No Client doesn't know Client refused

If yes, please list the Non-cash benefit source: _____

Covered by Health Insurance? Yes No Client doesn't know Client refused

General Health Status Excellent Very Good Good Fair Poor Client doesn't know Client refused

- The section below is required to be answered by CoC funded programs only

Client perceives their life has value and worth? strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree
 Client doesn't know Client refused Data Not Collected

Client perceives they have support from others who will listen to problems? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Client perceives they have a tendency to bounce back after hard times? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Client's frequency of feeling nervous, tense, worried, frustrated, or afraid? strongly disagree Somewhat disagree Neither agree nor disagree
 Somewhat agree Strongly agree Client doesn't know Client refused Data Not Collected

Disabling Conditions:

Substance Use Disorder: No Alcohol Drug Both Alcohol and Drug Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

Mental Health Disorder: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

Developmental Disability: No Yes Client doesn't know Client refused Data Not Collected

Chronic Health Condition: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

HIV/AIDS: No Yes Client doesn't know Client refused Data Not Collected

Physical Disability: No Yes Client doesn't know Client refused Data Not Collected

If Yes, Is this expected to be of long-continued indefinite duration and substantially impairs ability to live independently?

Yes No Client doesn't know Client refused Data Not Collected

FINANCIAL ASSESSMENT

Income received from any source? Yes No Client doesn't know Client refused Data Not Collected

Income Type	Monthly Amount	Income Type	Monthly Amount
Unemployment Insurance	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Retirement Income from Social Security	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Earned/Employed Income	<input type="checkbox"/> N <input type="checkbox"/> Y \$	VA Non-Service-Connected Disability Pension	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Supplemental Security Income (SSI)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Pension or Retirement income from a former job	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Social Security Disability Insurance (SSDI)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Child Support	<input type="checkbox"/> N <input type="checkbox"/> Y \$
VA Service-Connected Disability Compensation	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Alimony or other spousal support	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Private Disability Insurance	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Worker's Compensation	<input type="checkbox"/> N <input type="checkbox"/> Y \$
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Other Source, Specify below:	<input type="checkbox"/> N <input type="checkbox"/> Y \$
General Assistance (GA)	<input type="checkbox"/> N <input type="checkbox"/> Y \$	Client Total Income	

HEALTH ASSESSMENT

Health Insurance from any source? Yes No Client doesn't know Client refused Data Not Collected

Medicaid

State Children's Health Insurance Program

Employer-Provided Health Insurance

State Health Insurance for Adults

Indian Health Service Program

Other Specify: _____

Medicare

Veteran Administration (VA) Medical Services

Health Insurance obtained through COBRA

Private Pay Health Insurance

HOPWA Information

Receiving Public HIV/AIDS Medical Assistance? No Yes Client doesn't know Client refused Data Not Collected

Receiving AIDS Drug Assistance Program (ADAP)? No Yes Client doesn't know Client refused Data Not Collected

Receiving Ryan White-funded Medical or Dental Assistance? No Yes Client doesn't know Client refused Data Not Collected

Has the client been prescribed anti-retroviral drugs? No Yes Client doesn't know Client refused Data Not Collected

T-cell (CD4) and Viral Load

T-Cell (cd4) Count Available? No Yes Client doesn't know Client refused Data Not

If Yes, T-CELL COUNT: _____

How was the T-Cell count information obtained? Medical Report Client Report Other

Viral Load Information Available? Not Available Available Undetectable Client doesn't know Client refused
 Closed Alternate Schedule Change in Capacity Data Not Collected

Runaway Homeless Youth- Exit

Assessment Date: ____/____/____

Interval: _____

Counseling received by client: No Yes

Total number of sessions planned in youth's treatment or service plans: _____

A plan is in place to start or continue counseling after exit: No Yes

Exit Destination safe – as determined by the client: No Yes Client Doesn't Know Client Refused Data Not Collected

Exit Destination safe – as determined by the project/caseworker: No Yes Client Doesn't Know Client Refused Data Not Collected

Client has permanent positive adult connections outside of project: No Yes Worker does not Know

Client has permanent positive peer connections outside of project: No Yes Worker does not Know

Client has permanent positive community connections outside of project: No Yes Worker does not Know