

## HMIS Data Collection for RHY TLP Projects – EXIT

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### 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 these questions for all household members—each adult and child. A separate form should be included for each household member.

### DATA FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

Respond to these 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.

#### 3.11 PROJECT EXIT DATE (e.g., 09/06/2016)

##### (ALL CLIENTS)

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			

#### 3.1 NAME (first, middle, last name, suffix (e.g., Jr, Sr, III))

##### (ALL CLIENTS)

First name																			
Middle name																			
Last name																			
Suffix																			

**3.12 DESTINATION  
(ALL CLIENTS)**

<input type="checkbox"/> Deceased	<input type="checkbox"/> Rental by client, with VASH housing subsidy
<input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/> Rental by client, with GPD TIP housing subsidy
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
<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
<input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Client refused

**4.4 HEALTH INSURANCE  
(ALL CLIENTS)**

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	Type of health insurance
<input type="checkbox"/>	<input type="checkbox"/>	Private
<input type="checkbox"/>	<input type="checkbox"/>	Private - Employer
<input type="checkbox"/>	<input type="checkbox"/>	Private - Individual
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid (Medi-Cal)
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program S-CHIP
<input type="checkbox"/>	<input type="checkbox"/>	Military Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Other Public
<input type="checkbox"/>	<input type="checkbox"/>	State Funded
<input type="checkbox"/>	<input type="checkbox"/>	Combined Children's Health Insurance / Medicaid Program
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Service (IHS)
<input type="checkbox"/>	<input type="checkbox"/>	Other
<input type="checkbox"/>	<input type="checkbox"/>	No insurance

**4.10 ALCOHOL ABUSE PROBLEM  
(ALL CLIENTS)**

Does the client currently have an alcohol abuse problem?

No

Yes

Client doesn't know

Client refused



**[IF YES for alcohol abuse problem] Is client currently receiving services/treatment for this condition?**

No

Yes

Client doesn't know

Client refused

**[IF YES for alcohol abuse problem] Is the alcohol 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 problem] Is documentation of the disability and severity on file?**

No

Yes

**4.7 CHRONIC HEALTH CONDITION  
(ALL CLIENTS)**

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 client currently receiving services/treatment for this 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

**4.6 DEVELOPMENTAL DISABILITY  
(ALL CLIENTS)**

Does the client currently have a developmental disability?

No  
 Yes

Client doesn't know  
 Client refused



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

**4.10 DRUG ABUSE PROBLEM  
(ALL CLIENTS)**

Does the client currently have a drug abuse problem?

No  
 Yes

Client doesn't know  
 Client refused



**[IF YES for drug abuse problem] Is client currently receiving services/treatment for this condition?**

No  
 Yes

Client doesn't know  
 Client refused

**[IF YES for drug abuse problem] Is the drug 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 drug abuse problem] Is documentation of the disability and severity on file?**

No  
 Yes

**4.8 HIV/AIDS  
(ALL CLIENTS)**

Does the client currently have HIV/AIDS?

No  
 Yes

Client doesn't know  
 Client refused



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

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

**4.9 MENTAL HEALTH ILLNESS  
(ALL CLIENTS)**

Does the client currently have a mental health illness?

No  
 Yes

Client doesn't know  
 Client refused



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

No  
 Yes

Client doesn't know  
 Client refused

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

No  
 Yes

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**4.5 PHYSICAL DISABILITY  
(ALL CLIENTS)**

Does the client currently have a physical disability?

No  
 Yes

Client doesn't know  
 Client refused



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

**4.2 INCOME AND SOURCES**  
**(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)**

**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
Veteran's Disability Payment	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 (Social Security)	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
Veteran's Pension	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
Other Pension	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
Child Support	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
Alimony	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
Other Income If yes, specify	No <input type="checkbox"/>	
	Yes <input type="checkbox"/>	\$ . 0 0
<b>Total monthly income</b>	<b>Monthly income from all sources</b>	<b>\$ . 0 0</b>

**4.3 NON-CASH BENEFITS**  
**(HEAD OF HOUSEHOLD AND OTHER ADULTS ONLY)**

**Non-cash benefits from any source?**

No

Yes

Client doesn't know

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.) If unsure of the exact monthly amount, enter client's best estimate.**

Source of non-cash benefit	Receiving benefit from source?	If yes, monthly amount from source (round to nearest dollar)			
Food Stamps / Supplemental Nutrition Assistance Program (SNAP)	No				
	Yes	\$			. 0 0
MEDICAID	No				
	Yes				
MEDICARE	No				
	Yes				
State Children's Health Insurance Program	No				
	Yes				
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	No				
	Yes				
Veteran's Administration Medical Services	No				
	Yes				
TANF Child Care Services	No				
	Yes				
TANF Transportation Services	No				
	Yes				
Other TANF-Funded Services	No				
	Yes				
Section 8, Public Housing, or Other Rental Assistance	No				
	Yes				
Other source:	No				
	Yes				



#### 4.26 EMPLOYMENT STATUS

##### (HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)

Check the appropriate employment status at the time of assessment. If the client is employed, record the hours worked in the week prior to assessment, and select the tenure of the employment position. If the client is not employed, indicate if the client is looking for work.

- No
- Yes

- Client doesn't know
- Client refused



##### [IF YES] Type of Employment

- Full-time
- Part-Time
- Seasonal / sporadic (including day labor)



##### Hours worked last week

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##### Employment Tenure

- Permanent
- Temporary
- Seasonal

- Client doesn't know
- Client refused

##### [IF NO] Why not employed?

- Looking for work
- Unable to work
- Not looking for work

#### HEALTH ASSESSMENT

##### (HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)

#### 4.27 General Health Status

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

#### 4.28 Dental Health Status

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

**4.29 Mental Health Status**

- Excellent
- Very Good
- Good
- Fair

- Poor
- Client doesn't know
- Client refused

**4.30 Pregnancy Status  
(FEMALE CLIENTS ONLY)**

- No
- Yes

- Client doesn't know
- Client refused



**[IF YES] Provide the Pregnancy Due Date**

		/			/				
Month			Day			Year			

**RHY EXIT ASSESSMENT  
(HEAD OF HOUSEHOLD AND OTHER ADULTS AND UNACCOMPANIED YOUTH)**

**4.37 Project Completion Status**

- Completed project
- Youth voluntarily left early
- Youth was expelled or otherwise involuntarily discharged from project

**[IF YOUTH VOLUNTARILY LEFT EARLY] Left Early Reason**

- Left for other opportunities – Independent living
- Left for other opportunities – Education
- Left for other opportunities – Military
- Left for other opportunities – Other
- Needs could not be met by project

**[IF YOUTH EXPELLED OR INVOLUNTARILY LEFT] Involuntary Reason**

- Criminal activity / destruction of property / violence
- Non-compliance with project rules
- Non-payment of rent/ occupancy charge
- Reached maximum time allowed by project
- Project terminated
- Unknown / disappeared

#### 4.38 Family Reunification Achieved

No

Yes

Client doesn't know

Client refused

#### 4.36 Transitional, Exit-care, or Aftercare Plans and Actions

##### Actions

##### Action Status

Actions	Yes	No	Client refused
A written transitional, aftercare or follow-up plan or agreement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Advice about and/or referral to appropriate mainstream assistance programs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Placement in appropriate, permanent, stable housing (not a shelter)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Due to unavoidable circumstances or scarcities of appropriate housing, the youth must be transported or accompanied to a temporary shelter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exit counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A course of further follow-up treatment or service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A follow-up meeting or series of staff / youth meetings or contacts has been scheduled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A "package" of such things as maps, information about local shelters and resources	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>