DATA FOR ALL ADULTS

CLIENT (name or other identifier)

PROJECT EXIT DATE:

Month		/	Day		/	Year			

EXIT REASON:

☐ Completed Program	☐ Medical Treatment	☐ Reached Maximum Time Allowed
☐ Criminal Activity/Violence	☐ Needs Could Not Be Met	☐ Transfer
☐ Death	☐ Non-Compliance with Program	☐ No Progress
☐ Disagreement with Rules/Persons	☐ Non-Payment of Rent	☐ Unknown/Disappeared
☐ Left for Housing Opp. Before Completing Program	☐ Other:____________________	

EXIT DESTINATION:

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

INCOME AND SOURCES:

Does the client have any income from any source?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

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

Receiving Income?		Source of Income	Monthly amount from source (round to nearest dollar)						
☐No	☐Yes	Earned income (employment income)	$				.	0	0
☐No	☐Yes	Unemployment Insurance	$				.	0	0
☐No	☐Yes	Supplemental Security Income (SSI)	$				.	0	0
☐No	☐Yes	Social Security Disability Insurance (SSDI)	$				.	0	0
☐No	☐Yes	VA Service-Connected Disability Compensation	$				.	0	0
☐No	☐Yes	VA Non-Service-Connected Disability Pension	$				.	0	0
☐No	☐Yes	Private disability insurance	$				.	0	0
☐No	☐Yes	Worker's Compensation	$				.	0	0
☐No	☐Yes	Temporary Assistance for Needy Families (TANF)	$				.	0	0
☐No	☐Yes	General Assistance (GA)	$				.	0	0
☐No	☐Yes	Retirement Income from Social Security	$				.	0	0
☐No	☐Yes	Pension or retirement income from a former job	$				.	0	0
☐No	☐Yes	Child support	$				.	0	0
☐No	☐Yes	Alimony or other spousal support	$				.	0	0
☐No	☐Yes	Other source:______________________________	$				.	0	0
		Total monthly income from all sources	**$**				**.**	**0**	**0**

NON-CASH BENEFITS :

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

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

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

	Receiving Benefits?	
Supplemental Nutrition Assistance Program (SNAP)	☐No	☐Yes
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐No	☐Yes
TANF Child Care services *(or use local name)*	☐No	☐Yes
TANF transportation services *(or use local name)*	☐No	☐Yes
Other TANF-Funded Services *(or use local name)*	☐No	☐Yes
Other source, specify source:____	☐No	☐Yes

EMPLOYED?:

☐	Client refused	☐	Client doesn't know
☐	Yes **# of Hours/week:__________**	☐	No

- ☐ Full-time
- ☐ Part-time
- ☐ Seasonal/Sporadic

- ☐ Looking for work
- ☐ Unable to work
- ☐ Not Looking for work

MENTAL HEALTH LINKAGE

If linked with a mental health agency, which one?:

____

- ☐ Not currently linked but NEEDS linkage
- ☐ Not currently linked, does NOT need linkage

HEALTH INSURANCE

Is the client currently covered by health insurance?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

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

No	Yes	Source
☐	☐	Medicaid
☐	☐	Medicare
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other If Yes, specify source: ______________________

-- ***Begin HIPAA Assessment*** --

Pregnant?:

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Projected Due Date:

		/			/				

Month Day Year

DISABLING CONDITION

Does the client have a disabling condition that is long-term and impairs their ability to live independently?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] Answer 'Yes' or 'No' for each Disability Type.

No	Yes	Disability Type	Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?
☐	☐	Physical Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Developmental Disability	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Chronic Health Condition	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	HIV/AIDS	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Mental Health Problem	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Substance Abuse: ☐Drug ☐Alcohol ☐Both Drug & Alcohol	☐No ☐Yes ☐Doesn't Know ☐Refused
☐	☐	Other If Yes, specify source: ____________________	☐No ☐Yes ☐Doesn't Know ☐Refused

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] When did the experience occur?

☐	Within the past three months	☐	One year ago or more
☐	Three to six months ago (excluding six months exactly)	☐	Client doesn't know
☐	Six months to one year ago (excluding one year exactly)	☐	Client refused

[IF YES] Is the client currently fleeing?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

-- ***End HIPAA Assessment*** --

Monthly Rent & Utilities (Combined):

HOUSING MOVE-IN DATE (e.g., 08/24/2017)

The Housing Move-In Date is the day the client moved into a Permanent Housing unit.

		/			/				

Month Day Year

(Prevention Projects Only)

HOUSING ASSESSMENT AT EXIT

☐	Able to maintain the housing they had at project entry
☐	Moved to new housing unit
☐	Moved in with family/friends on a temporary basis
☐	Moved in with family/friends on a permanent basis
☐	Moved to a transitional or temporary housing facility or program
☐	Client became homeless – moving to a shelter or other place unfit for human habitation
☐	Client went to jail/prison
☐	Client died
☐	Client doesn't know
☐	Client refused

IF YES for able to maintain the housing they had at project entry] Subsidy Information

☐	Without a subsidy
☐	With the subsidy they had at project entry
☐	With an on-going subsidy acquired since project entry
☐	Only with financial assistance other than a subsidy

[IF YES for moved to a new housing unit] Subsidy Information

☐	With an ongoing subsidy
☐	Without an ongoing subsidy

Client Signature:____**Date:**____________

Staff Signature:____**Date:**____________