DATA FOR ALL Children

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:

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

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***----------

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

Pregnant?:

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

Projected Due Date:

		/			/				
Month			Day			Year			

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

Client Signature:_____ **Date:**_____

Staff Signature:_____ **Date:**_____