

# HMIS Universal Exit/Update Form - Child

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

- Update                       Annual Review                       Exit

Client Name: \_\_\_\_\_ Update/Exit Date: 

		/			/				
<small>month</small>			<small>day</small>			<small>year</small>			

## 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      |                              |

## Health Insurance

Covered by health insurance (all clients)

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

Answer 'Yes' or 'No' for each health insurance source.  
(Based on the status at the time of entry)

No Yes Source of insurance coverage

Medicaid

Medicare

State Children's Health Insurance Program

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 source: \_\_\_\_\_