HMIS Data Collection Form for Project EXIT/Annual Review – All Projects (Excluding RHY)

DATA FOR ALL ADULTS A separate form should be included for each household member. Each household member may have separate exit dates, destinations, etc.

FORM TYPE:

Project Exit ☐ **Annual Review** ☐ **No Exit Interview Completed** ☐

CLIENT (name or other identifier)

PROJECT EXIT/REVIEW DATE (e.g., 08/24/2017)

The Project Exit Date will serve as the information date for all data elements collected on this form.

		/			/				
Month			Day			Year			

EXIT REASON

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

DESTINATION

Which of the following most closely matches where the client will be staying right after leaving this project?

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		☐ Rental by client, with GPD TIP housing subsidy
	☐ Transitional Housing for homeless persons (including homeless youth)	Rent/Own with Subsidy	☐ Rental by client, with VASH housing subsidy
	☐ Hotel or motel paid for without emergency shelter voucher		☐ Rental by client, with other ongoing housing subsidy
Non-Homeless Temporary Situations	☐ 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)		☐ Rental by client, no ongoing housing subsidy
	☐ Staying or living with friends, temporary tenure (room, apartment, or house)	Rent/ Own no Subsidy	☐ Owned by client, no ongoing housing subsidy
	☐ Psychiatric hospital or other psychiatric facility		☐ 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
	☐ Hospital or other residential non-psychiatric medical facility		☐ Deceased
	☐ Jail, prison, or juvenile detention facility	Other	☐ Other:_____
	☐ Foster care home or foster care group home		☐ Client doesn't know
	☐ Long-term care facility or nursing home		☐ Client refused

INCOME AND SOURCES

Only record regular, recurrent sources that are current as of today (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income).

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.

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. Answer 'No' for sources that have been terminated, even if they were received in the past.

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

NON-CASH BENEFITS

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

Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.

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

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

Source of income	Receiving Benefits from source?
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 If yes, specify source:_____	☐ No ☐ Yes

EMPLOYMENT INFORMATION

Employed?

- ☐ Client refused
- ☐ Yes **# of Hours/week:**_____
  - ☐ Full-time
  - ☐ Part-time
  - ☐ Seasonal/Sporadic (including day labour)
- ☐ Client doesn't know
- ☐ No
  - ☐ 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.

Answer 'No' for sources that have been terminated, even if they were received in the past.

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 currently have a disabling condition?
A disabling condition is any of the below-indicated disabilities or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long–continued and indefinite duration and substantially impairs 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	[IF YES], 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			

Birth Weight:

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*----------

MILITARY INFORMATION

Entered Military Service:

		/			/				
Month			Day			Year			

Separated from Military Service:

		/			/				
Month			Day			Year			

Military Branch:

Discharge Status:

Operation	Has the client participated in the following military operations?			
World War II	☐No	☐Yes	☐Doesn't Know	☐Refused
Korean War	☐No	☐Yes	☐Doesn't Know	☐Refused
Vietnam War	☐No	☐Yes	☐Doesn't Know	☐Refused
Persian Gulf War	☐No	☐Yes	☐Doesn't Know	☐Refused
Afghanistan	☐No	☐Yes	☐Doesn't Know	☐Refused
Iraqi Freedom	☐No	☐Yes	☐Doesn't Know	☐Refused
Iraqi Dawn	☐No	☐Yes	☐Doesn't Know	☐Refused
Other Peace-keeping Operations or Military Interventions: _____	☐No	☐Yes	☐Doesn't Know	☐Refused

ADULT EDUCATION INFORMATION

Highest Level of Education Attained:

Degree Earned (e.g. Bachelor's Degree, Associate's Degree, GED, etc.):

Degree Status (Complete: Cert. Received/Not Received, In Progress, Incomplete):

Start Date:

		/			/				
Month			Day			Year			

End Date:

		/			/				
Month			Day			Year			

Received Vocational Training?

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

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			

Housing Assessment at Exit (Prevention Project Only)

☐	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:** _____