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

DATA FOR ALL CHILDREN 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 meat 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

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
- ☐ Yes
- ☐ Client doesn't know
- ☐ Client refused

Projected Due Date:

		/			/				
Month			Day			Year			

Birth Weight:

DOMESTIC VIOLENCE

Is client a domestic violence victim/survivor?

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

[IF YES] When did the experience occur?

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

[IF YES] Is the client currently fleeing?

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

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

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 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:_____