

KS BOS HMIS

CoC/ESG Exit Form – All Project Types

CLIENT NAME									
Last:									
First:									
Middle:						Suffix			
PROJECT NAME									
PROJECT EXIT DATE (MM/DD/YYYY)									
DESTINATION (ALL CLIENTS)									
<input type="checkbox"/> Place not meant for habitation (vehicle, anywhere outside)					<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH				
<input type="checkbox"/> Emergency Shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded Host Home					<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH				
<input type="checkbox"/> Safe Haven					<input type="checkbox"/> Rental by client, with GPD TIP subsidy				
<input type="checkbox"/> Foster care home or foster care group home					<input type="checkbox"/> Rental by client, with VASH housing subsidy				
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility					<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons				
<input type="checkbox"/> Jail, prison or juvenile detention facility					<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy				
<input type="checkbox"/> Long-term care facility or nursing home					<input type="checkbox"/> Rental by client, with HCV voucher				
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility					<input type="checkbox"/> Rental by client in a public housing unit				
<input type="checkbox"/> Substance abuse treatment facility or detox center					<input type="checkbox"/> Rental by client, no ongoing housing subsidy				
<input type="checkbox"/> Residential project or halfway house with no homeless criteria					<input type="checkbox"/> Rental by client, with other ongoing housing subsidy				
<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"/> Transitional housing for homeless persons (including homeless youth)					<input type="checkbox"/> Owned by client, with other ongoing housing subsidy				
<input type="checkbox"/> Host Home (non-crisis)					<input type="checkbox"/> No Exit Interview Completed				
<input type="checkbox"/> Staying or living with friends, temporary tenure					<input type="checkbox"/> Other				
<input type="checkbox"/> Staying or living with family, temporary tenure					<input type="checkbox"/> Deceased				
<input type="checkbox"/> Staying or living with friends, permanent tenure					<input type="checkbox"/> Client doesn't know				
<input type="checkbox"/> Staying or living with family, permanent tenure					<input type="checkbox"/> Client refused				
					<input type="checkbox"/> Data not collected				

Permanent Housing Projects Only (PSH, RRH, PH)

If Client is in a <u>Permanent Housing Situation</u> at time of Exit:										
HOUSING MOVE-IN DATE <i>(enter on <u>Enrollment Screen</u> for Head of Household)</i>										
					MONTH	DAY		YEAR		

Homelessness Prevention Projects Only

HOUSING ASSESSMENT AT EXIT	
<input type="checkbox"/> Able to maintain the housing they had at project entry* <input type="checkbox"/> Moved to new housing unit* <input type="checkbox"/> Moved in with family/friends, temporary basis <input type="checkbox"/> Moved in with family/friends, permanent basis <input type="checkbox"/> Moved to a transitional or temporary housing facility or program	<input type="checkbox"/> Client became homeless – moving to a shelter or other place unfit for human habitation <input type="checkbox"/> Client went to jail/prison <input type="checkbox"/> Client died <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If ABLE TO MAINTAIN HOUSING THEY HAD AT PROJECT ENTRY	
Subsidy Information	<input type="checkbox"/> Without a subsidy <input type="checkbox"/> With the subsidy they had at project entry <input type="checkbox"/> With an on-going subsidy acquired since project entry <input type="checkbox"/> Only w/ financial assistance other than a subsidy
*If MOVED TO NEW HOUSING UNIT	
Subsidy Information	<input type="checkbox"/> With on-going subsidy <input type="checkbox"/> Without an on-going subsidy

Night by Night Emergency Shelters & Street Outreach Projects Only

If client has become Engaged by project:										
DATE OF ENGAGEMENT <i>(enter on <u>Enrollment Screen</u> for All Clients)</i>										
					MONTH	DAY		YEAR		

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Physical Disability <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Chronic Health Condition <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Mental Health Problem <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
MENTAL HEALTH PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES for Substance Abuse Problem <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Yes*	<input type="checkbox"/> Client refused	
	<input type="checkbox"/> Data not collected	
*If YES to Domestic Violence Victim/Survivor		
When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CASH INCOME FOR INDIVIDUAL		
Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Income from Any Source – Indicate all sources that apply		
Income Source (Check all that apply)	Monthly Amount	
<input type="checkbox"/> Earned Income		
<input type="checkbox"/> Unemployment Insurance		
<input type="checkbox"/> Supplemental Security Income (SSI)		
<input type="checkbox"/> Social Security Disability Insurance (SSDI)		
<input type="checkbox"/> VA Service-Connected Disability Compensation		
<input type="checkbox"/> VA Non-Service Connected Disability Compensation		
<input type="checkbox"/> Private Disability Insurance		
<input type="checkbox"/> Worker's Compensation		
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)		
<input type="checkbox"/> General Assistance (GA)		
<input type="checkbox"/> Retirement Income from Social Security		
<input type="checkbox"/> Pension or Retirement Income from a Former Job		
<input type="checkbox"/> Child Support		
<input type="checkbox"/> Alimony and Other Spousal Support		
<input type="checkbox"/> Other Cash Income (Specify: _____)		
Total Monthly Amount		

NON-CASH BENEFITS			
Receiving Non-Cash Benefits?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Yes*		<input type="checkbox"/> Data not collected
*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply			
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/> TANF Transportation Services		
<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/> Other TANF-Funded Services		
<input type="checkbox"/> TANF Childcare Services	<input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)		

HEALTH INSURANCE			
Covered by Health Insurance?	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
	<input type="checkbox"/> Yes*		<input type="checkbox"/> Data not collected
*If YES to Covered by Health Insurance – Indicate all sources that apply			
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Health Insurance Obtained Through COBRA		
<input type="checkbox"/> Medicare	<input type="checkbox"/> Private Pay Health Insurance		
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> State Health Insurance for Adults		
<input type="checkbox"/> Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Indian Health Services Program		
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Other Health Insurance (Specify source: _____)		

CONTACT INFORMATION (Optional – entered on the Contacts tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the Locations tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date