Alameda County HMIS

CLARITY HMIS: HUD-HOPWA PROJECT EXIT FORM
Use block letters for text and bubble in the appropriate circles.
Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER:_____

PROJECT EXIT DATE *[All Clients]*

		/			/			
Month			**Day**			**Year**		

DESTINATION *[All Clients]*

○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside)	○	Moved from one HOPWA funded project to HOPWA TH
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter	○	Staying or living with family, permanent tenure
○	Safe Haven	○	Staying or living with friends, permanent tenure
○	Foster care home or foster care group home	○	Moved from one HOPWA funded project to HOPWA PH
○	Hospital or other residential non-psychiatric medical facility	○	Rental by client, no ongoing housing subsidy
○	Jail, prison or juvenile detention facility	○	Rental by client, with ongoing housing subsidy
○	Long-term care facility or nursing home	○	Owned by client, with on-going housing subsidy
○	Psychiatric hospital or other psychiatric facility	○	Owned by client, no on-going housing subsidy
○	Substance abuse treatment facility or detox center	○	No exit interview completed
○	Transitional housing for homeless persons (including homeless youth)	○	Other
○	Residential project or halfway house with no homeless criteria	○	Deceased
○	Hotel or motel paid for without emergency shelter voucher	○	Client doesn't know
○	Host Home (non-crisis)	○	Client prefers not to answer
○	Staying or living in a friend's room, apartment, or house	○	Data not collected
○	Staying or living in a family member's room, apartment or house		
IF "RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY" – SPECIFY:			
○	GPD TIP housing subsidy	○	Emergency Housing Voucher
○	VASH Housing subsidy	○	Family Unification Program Voucher (FUP)
○	RRH or equivalent subsidy	○	Foster Youth to Independence Initiative (FYI)
○	HCV voucher (tenant or project based) (not dedicated)	○	Permanent Supportive Housing

○	Public Housing Unit	○	Other permanent housing dedicated for formerly homeless persons
○	Rental by client, with other ongoing housing subsidy		

HOUSING ASSESSMENT AT EXIT *[All Clients]*

○	Able to maintain the housing they had at project entry	○	Jail/prison
○	Moved to new housing unit	○	Deceased
○	Moved in with family/friends on a temporary basis	○	Client doesn't know
○	Moved in with family/friends on a permanent basis	○	Client prefers not to answer
○	Moved to a transitional or temporary housing facility or program	○	Data not collected
○	Client became homeless – moving to a shelter or other place unfit for human habitation		

IF "ABLE TO MAINTAIN HOUSING AT PROJECT ENTRY" TO HOUSING ASSESSMENT

Subsidy Information

○	Without a subsidy	○	With an on-going subsidy acquired since project entry
○	With the subsidy they had at project entry	○	Only with financial assistance other than a subsidy

IF "MOVED TO NEW HOUSING UNIT" TO HOUSING ASSESSMENT

Subsidy Information

○	With on-going subsidy	○	Without an on-going subsidy

PHYSICAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No ○ Yes	○ ○ ○	Client doesn't know Client prefers not to answer Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No ○ Yes	○ ○ ○	Client doesn't know Client prefers not to answer Data not collected

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Alcohol use disorder	○	Client prefers not to answer
○	Drug use disorder	○	Data not collected
○	Both alcohol and drug use disorders		

IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○ No	○	Client doesn't know
	○ Yes	○	Client prefers not to answer
		○	Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

Income Source		Amount	Income Source		Amount
○	Earned Income		○	Temporary Assistance for Needy Families (TANF)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or retirement income from a former job	
○	VA Service-Connected Disability Compensation		○	Child support	
○	VA Non-Service-Connected Disability Pension		○	Alimony and other spousal Support	
○	Private Disability Insurance		○	Other income source *(specify):*	
○	Worker's Compensation				
Total Monthly Income for Individual:					

RECEIVING NON-CASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know

○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	Supplemental Nutrition Assistance Program (SNAP)	○	TANF Child Care Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	TANF Transportation Services
○	Other (specify):	○	Other TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No		○	Client doesn't know
○	Yes		○	Client prefers not to answer
			○	Data not collected
IF "YES" TO HEALTH INSURANCE & REASONS NOT COVERED BY NON-CHOSEN SELECTION(S)				
○	MEDICAID		○	Applied; decision pending
			○	Applied; client not eligible
			○	Client did not apply
			○	Insurance type N/A for this client
			○	Client doesn't know
			○	Client prefers not to answer
			○	Data not collected
○	MEDICARE		○	Applied; decision pending
			○	Applied; client not eligible
			○	Client did not apply
			○	Insurance type N/A for this client
			○	Client doesn't know
			○	Client prefers not to answer
			○	Data not collected
○	State Children's Health Insurance (SCHIP)		○	Applied; decision pending
			○	Applied; client not eligible
			○	Client did not apply
			○	Insurance type N/A for this client
			○	Client doesn't know
			○	Client prefers not to answer
			○	Data not collected
○	Veteran's Health Administration (VHA)		○	Applied; decision pending
			○	Applied; client not eligible
			○	Client did not apply
			○	Insurance type N/A for this client
			○	Client doesn't know
			○	Client prefers not to answer
			○	Data not collected
○	Employer Provided Health Insurance		○	Applied; decision pending
			○	Applied; client not eligible
			○	Client did not apply
			○	Insurance type N/A for this client
			○	Client doesn't know
			○	Client prefers not to answer
			○	Data not collected

○	Health Insurance Obtained through COBRA	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Private Pay Health Insurance	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	State Health Insurance for Adults	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Indian Health Services Program	○	Applied; decision pending
		○	Applied; client not eligible
		○	Client did not apply
		○	Insurance type N/A for this client
		○	Client doesn't know
		○	Client prefers not to answer
		○	Data not collected
○	Other Health Insurance (specify)		

IF "YES" TO HIV-AIDS:

Receiving AIDS Drug Assistance Program (ADAP)

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "NO" TO RECEIVING AIDS DRUG ASSISTANCE PROGRAM (ADAP) – SPECIFY REASON			
○	Applied; decision Pending	○	Client doesn't know
○	Applied; client not eligible	○	Client prefers not to answer
○	Client did not apply	○	Data not collected
○	Insurance type N/A for this client		

Receiving Ryan White-funded Medical or Dental Assistance

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "NO" TO RECEIVING RYAN WHITE-FUNDED MEDICAL OR DENTAL ASSISTANCE – SPECIFY REASON			
○	Applied; decision pending	○	Client doesn't know

○	Applied; client not eligible	○	Client prefers not to answer
○	Client did not apply	○	Data not collected
○	Insurance type N/A for this client		

T-cell (CD4) Count Available

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

T-cell Count (Integer between 0-1500): _____
How Was the Information Obtained?

○	Medical Report
○	Client report
○	Other (specify)

Viral Load Information Available

○	Not available	○	Client doesn't know
○	Available	○	Client prefers not to answer
○	Undetectable	○	Data not collected

Count (Integer between 0-999999): _____
How Was the Information Obtained?

○	Medical Report
○	Client report
○	Other (specify)

Has the participant been prescribed anti-retroviral drugs?

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IN PERMANENT HOUSING *[Permanent Housing Projects, for Head of Household]*

○	No	○	Yes
IF "YES" TO PERMANENT HOUSING			
Housing Move-In Date:*		_____/_____/_____	
*If client moved into permanent housing, make sure to update on the **enrollment screen**.*			

CONTACT INFORMATION *[Optional – can be entered in Contact Tab]*

Contact Type										
Email										
Phone (#1)										
Phone (#2)										
Active Contact	○	Yes					○	No		

Private	○	Yes	○	No
Contact Date				
Note				

CURRENT ADDRESS (IF APPLICABLE) *[Optional – can be entered in Location Tab]*

Street	
City	
Street		Zip Code	

_____

Signature of applicant stating all information is true and correct   Date