

HMIS EXIT Data Collection Form for Solano County Projects

General Instructions

This is the exit form for ALL projects in Solano County except for PATH, RHY, and VA programs. This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household. If a household presents as two minor youth, one of the youth should be designated as the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response. Please note that current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary. If the data dictionary does not answer your question, please reach out to solanoHMIS@homebaseccc.org for assistance.

CLIENT NAME:

DATE ADMINISTERED:

EXIT DESTINATION

PROJECT EXIT DATE

The Project Exit Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

		/			/				
Month			Day			Year			

REASON FOR LEAVING

<input type="checkbox"/>	Completed program	<input type="checkbox"/>	Disagreement with rules or persons
<input type="checkbox"/>	Left for housing opportunity before completing program	<input type="checkbox"/>	Criminal activity or violence
<input type="checkbox"/>	Reached maximum time allowed	<input type="checkbox"/>	Death
<input type="checkbox"/>	Needs could not be met	<input type="checkbox"/>	Unknown or disappeared
<input type="checkbox"/>	Non-compliance with program	<input type="checkbox"/>	If OTHER , specify: _____
<input type="checkbox"/>	Non-payment of rent		

DESTINATION

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

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA PH
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<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 housing subsidy
<input type="checkbox"/>	Foster care 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 (tenant or project based)
<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, with ongoing housing subsidy
<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/>	Owned by client, no 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"/>	If OTHER , specify: _____
<input type="checkbox"/>	Staying or living with family, temporary tenure	<input type="checkbox"/>	Deceased
<input type="checkbox"/>	Staying or living with family, permanent tenure	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Staying or living with friends, permanent tenure	<input type="checkbox"/>	Client refused

EXIT DESTINATION (CONTINUED)

NOTES

EXIT LOCATION

Where will the client live after exiting? Select the location from the list below.

<input type="checkbox"/>	Benicia	<input type="checkbox"/>	Other area in Solano County
<input type="checkbox"/>	Birds Landing	<input type="checkbox"/>	Alameda County
<input type="checkbox"/>	Dixon	<input type="checkbox"/>	Contra Costa County
<input type="checkbox"/>	Fairfield	<input type="checkbox"/>	Napa County
<input type="checkbox"/>	Green Valley	<input type="checkbox"/>	Sacramento County
<input type="checkbox"/>	Rio Vista	<input type="checkbox"/>	San Francisco County
<input type="checkbox"/>	Suisun City	<input type="checkbox"/>	Yolo County
<input type="checkbox"/>	Vacaville	<input type="checkbox"/>	Other area in California (non-Solano)
<input type="checkbox"/>	Vallejo	<input type="checkbox"/>	Other area outside of California

DISABILITIES

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond "yes" to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

SUBSTANCE USE DISORDER

<input type="checkbox"/>	Yes: Alcohol use disorder only	<input type="checkbox"/>	No
<input type="checkbox"/>	Yes: Drug use disorder only	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Yes: Both alcohol and drug use disorders	<input type="checkbox"/>	Client refused



If **YES** for alcohol use disorder, drug use disorder, or both alcohol and drug use disorder, is the disability expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

CHRONIC HEALTH CONDITION

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for chronic health condition, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DEVELOPMENTAL

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for developmental disability, is the disability expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DISABILITIES (CONTINUED)

HIV/AIDS

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **HIV/AIDS**, is the disability expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

MENTAL HEALTH DISORDER

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **mental health disorder**, is the disability expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

PHYSICAL

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know



If **YES** for **physical disability**, is the disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

IF YES, DISABILITY START DATE

		/			/			
Month			Day			Year		

NOTE ON DISABILITY

DISABLING CONDITION

A disabling condition is any of the above-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 impair ability to live independently. **Does the client currently have a disabling condition?**

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

INCOME

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household should be recorded under the Head of Household's information. If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
------------------------------	-----------------------------	--	---



If **YES**, answer 'Yes' or 'No' for each income source.

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

What is the client's income as a percentage of Area Median Income (AMI)?

<input type="checkbox"/> < 30%	<input type="checkbox"/> 30–50%	<input type="checkbox"/> > 50%
--------------------------------	---------------------------------	--------------------------------

Does the client have a connection with SSI/SSDI Outreach, Access, and Recovery (SOAR)?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused

NON-CASH BENEFITS

Only record regular, recurrent sources that are current (i.e. not terminated). Non-cash benefits received for a minor member of the household should be recorded under the Head of Household's information. Answer 'No' for sources that have been terminated, even if they were received in the past.

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

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
------------------------------	-----------------------------	--	---



If **YES**, answer 'Yes' or 'No' for each non-cash benefit source.

Source of Non-Cash Benefit	Receiving source?		If YES, date client began receiving source	If YES, monthly amount from source (round to nearest dollar)							
	Yes	No		\$							
Supplemental Nutrition Assistance Program, (i.e. CalFresh or Food Stamps)	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									
TANF Child Care services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									
TANF Transportation Services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									
Other TANF-Funded Services	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									
Other: _____	Yes	<input type="checkbox"/>		\$.	0	0
	No	<input type="checkbox"/>									

HEALTH INSURANCE

Only record regular, recurrent sources that are current (i.e. not terminated). Answer 'No' for sources that have been terminated, even if they were received in the past.

Is the client currently covered by health insurance?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused
------------------------------	-----------------------------	--	---



If **YES**, answer 'Yes' or 'No' for each health insurance source.

Source of Health Insurance	Receiving health insurance source?		If YES, date client began receiving source	For HOPWA, specify private pay insurance source, if applicable	For HOPWA, specify reason not covered, if applicable
Medicaid (i.e. Medi-Cal)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Medicare	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Children's Health Insurance Program (CHIP)	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Veteran's Administration (VA) Medical Services	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Employer-Provided Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Health insurance obtained through COBRA	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Private Pay Health Insurance	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
State Health Insurance for Adults	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Indian Health Services Program	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			
Other: _____	Yes	<input type="checkbox"/>			
	No	<input type="checkbox"/>			

MOVING ON

Programs other than Permanent Supportive Housing may leave questions on Moving On assistance blank.

DATE OF MOVING ON ASSISTANCE

		/			/				
Month			Day			Year			

TYPE OF ASSISTANCE			
<input type="checkbox"/>	Subsidized housing application assistance	<input type="checkbox"/>	Housing referral/placement
<input type="checkbox"/>	Financial assistance for Moving On (e.g. security deposit, moving expenses)	<input type="checkbox"/>	Other: _____
<input type="checkbox"/>	Non-financial assistance for Moving On (e.g. housing navigation, transition support)		

CONTACT INFORMATION

Address _____ Apt/Unit _____

City _____ State _____ ZIP Code _____ County _____

County _____

What is the data quality of the client's residence or last permanent address?

<input type="checkbox"/>	Full address reported	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Incomplete or estimated address reported	<input type="checkbox"/>	Client refused

Phone number _____ Email address _____

START DATE

		/			/			
--	--	---	--	--	---	--	--	--

Month

Day

Year

END DATE (if applicable)

		/			/			
--	--	---	--	--	---	--	--	--

Month

Day

Year

Landlord's Name _____ Landlord's Address _____

Landlord's City _____ Landlord's State _____ Landlord's Phone _____

EMERGENCY CONTACT

Contact's Name _____ Contact's Address _____

Contact's City _____ Contact's State _____ Landlord Phone _____

Second Phone Number _____ Relationship to Client _____

START DATE

		/			/			
--	--	---	--	--	---	--	--	--

Month

Day

Year

END DATE (if applicable)

		/			/			
--	--	---	--	--	---	--	--	--

Month

Day

Year