



Homeless Management Information System

Agency Name: _____

HMIS HPRP DATA: EXIT FORM – To be completed for ALL household members.

Use block letters for text and mark appropriate boxes with an “X”.
Complete a separate form for each household member.

<input type="checkbox"/>	Single Individual – No Dependents	<input type="checkbox"/>	Household Members Form Attached
			Client Relationship to Case: <i>[head of hh, spouse, child, etc]</i>

EXIT DATE *[All clients]*

	-		-	
Month		Day		Year

1. CURRENT NAME (first, middle, last name, suffix) *[All Clients]*

	N/A	does not know	refused to provide
First Name		<input type="checkbox"/>	<input type="checkbox"/>
Middle Name	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Last Name		<input type="checkbox"/>	<input type="checkbox"/>

2. PHONE NUMBER (optional): _____

3. HOUSING STATUS AT EXIT *[All Clients]*

<input type="checkbox"/>	Literally Homeless	<input type="checkbox"/>	Stably Housed
<input type="checkbox"/>	Imminent Risk of Literally Homeless	<input type="checkbox"/>	Client does not know.
<input type="checkbox"/>	Housed and at Risk of Losing Housing	<input type="checkbox"/>	Client refused to provide.

4. REASON FOR LEAVING *[All Clients]*

<input type="checkbox"/>	Left for a housing opportunity before completing program	<input type="checkbox"/>	Needs could not be met
<input type="checkbox"/>	Completed program	<input type="checkbox"/>	Disagreement with rules/persons
<input type="checkbox"/>	Non-payment of rent/occupancy charge	<input type="checkbox"/>	Death
<input type="checkbox"/>	Non-compliance with program	<input type="checkbox"/>	Refused to say
<input type="checkbox"/>	Criminal activity/destructive behavior	<input type="checkbox"/>	Disappeared/lost contact
<input type="checkbox"/>	Reached maximum time allowed	<input type="checkbox"/>	Other:



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5. DESTINATION AFTER LEAVING *[All Clients]*

<input type="checkbox"/>	Emergency shelter	<input type="checkbox"/>	Trans housing for homeless persons
<input type="checkbox"/>	Perm housing for former homeless	<input type="checkbox"/>	Psychiatric hospital or facility
<input type="checkbox"/>	Substance abuse treatment facility	<input type="checkbox"/>	Hospital (non-psychiatric)
<input type="checkbox"/>	Jail, prison or juvenile detention	<input type="checkbox"/>	Rented by Client, no subsidy
<input type="checkbox"/>	Owned by Client, no subsidy	<input type="checkbox"/>	Living with Family/Relative (temporary)
<input type="checkbox"/>	Living with Family/Relative (permanent)	<input type="checkbox"/>	Living with Friends (temporary)
<input type="checkbox"/>	Living with Friends (permanent)	<input type="checkbox"/>	Hotel or motel, no voucher subsidy
<input type="checkbox"/>	Foster care family or group home	<input type="checkbox"/>	Place not meant for human habitation
<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>	Rental by Client, VASH subsidy
<input type="checkbox"/>	Rental by Client, non-VASH subsidy	<input type="checkbox"/>	Owned by Client with housing subsidy
<input type="checkbox"/>	Deceased	<input type="checkbox"/>	Refused
<input type="checkbox"/>	Other:		

6. EXPECTED DURATION OF DESTINATION *[All Clients]*

<input type="checkbox"/>	Unknown	<input type="checkbox"/>	Permanent
<input type="checkbox"/>	Transitional	<input type="checkbox"/>	Refused

7. SOURCE OF SUPPORT AT DESTINATION *[All Clients]*

<input type="checkbox"/>	None	<input type="checkbox"/>	Public Housing
<input type="checkbox"/>	Section 8	<input type="checkbox"/>	Shelter Plus Care
<input type="checkbox"/>	HOME Program	<input type="checkbox"/>	HOPWA Program
<input type="checkbox"/>	Other Housing Subsidy	<input type="checkbox"/>	Refused
<input type="checkbox"/>	Unknown	<input type="checkbox"/>	Other:



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8. CASH INCOME AT EXIT *[All Clients, last 30 days]*

<input type="checkbox"/>	Client has NO income
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Source of Income Amount	Amount	Source of Income
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Earned Income (employment)		Veterans Pension	
Unemployment Insurance		Pension from Employment	
Workers Compensation		Temporary Assistance for Needy Families (TANF)	
Private Disability Insurance		General Public Assistance [GA]	
Veterans Disability Payments		Alimony or Spouse Support	
SSDI [Social Security Disability]		Child Support	
SSI [Supplemental Social Security]		Other Case Income [Not Listed]	
Social Security [Retirement]			

9. TOTAL INDIVIDUAL INCOME: _____

10. TOTAL HOUSEHOLD INCOME: _____

[Household income should include any income from all household sources i.e.; spouse, roommate, etc.]

11. NON-CASH BENEFITS AT EXIT *[All Clients, last 30 days]*

<input type="checkbox"/>	Client has NO benefits
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<input type="checkbox"/>	Food Stamps or Benefit Card	<input type="checkbox"/>	MedicAID (Health Insurance)
<input type="checkbox"/>	WIC	<input type="checkbox"/>	MeciCARE (Health Insurance)
<input type="checkbox"/>	Section 8 Public Housing or Rental Assistance	<input type="checkbox"/>	TANF Child Care Services
<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	TANF Transportation Services
<input type="checkbox"/>	SCHIP (State Children's Health Insurance Program)	<input type="checkbox"/>	Other TANF Funded Services
<input type="checkbox"/>	Other Non Cash Benefits		

12. PHYSICAL DISABILITY *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

13. RECEIVING SERVICES FOR PHYSICAL DISABILITY *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

14. DEVELOPMENTAL DISABILITY *[All Clients]*

<input type="checkbox"/>	Unknown	<input type="checkbox"/>	No
<input type="checkbox"/>	Retardation	<input type="checkbox"/>	Learning Disability
<input type="checkbox"/>	Other:		

15. RECEIVING SERVICES FOR DEVELOPMENTAL DISABILITY *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

16. CHRONIC HEALTH CONDITION *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

17. RECEIVING SERVICES FOR CHRONIC HEALTH CONDITION *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

18. HIV/AIDS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

19. RECEIVING SERVICES FOR HIV/AIDS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

20. MENTAL HEALTH PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

21. EXPECTED LONG-TERM MENTAL HEALTH PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

22. RECEIVING SERVICES FOR MENTAL HEALTH PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

23. ALCOHOL ABUSE PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

24. DRUG ABUSE PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

25. EXPECTED LONG-TERM SUBSTANCE ABUSE PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

26. RECEIVING SERVICES FOR SUBSTANCE ABUSE PROBLEMS *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

27. DOMESTIC VIOLENCE EXPERIENCE *[All Clients]*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
<input type="checkbox"/>	Don't Know	<input type="checkbox"/>	Refused

28. IF YES, TIME SINCE LAST DOMESTIC VIOLENCE EXPERIENCE *[All Clients]*

<input type="checkbox"/>	Unknown	<input type="checkbox"/>	Refused
<input type="checkbox"/>	Over a year ago	<input type="checkbox"/>	Within the last 3 months
<input type="checkbox"/>	Within the last 4-6 months	<input type="checkbox"/>	Within the last 6-12 months

STAFF PROCESSING TERMINATION _____