

HMIS #
CM Name
Project Exit Date / /

**Santa Cruz County HMIS YHDP - Standard Exit**

This form is designed to be completed by a service provider while interviewing a client.

A separate Standard Exit form should be completed for each member of the household.

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| **Client Profile**  |
| **First Name** |  | **Middle** |
| **Last Name** |  |  |
| **Alias** (If multiple aliases, separate by commas) |  |

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| **Destination** |
|  Deceased Emergency shelter, including hotel or motel paid for with emergency shelter voucher Foster care home or foster care group home Hospital or other residential non—psychiatric medical facility Hotel or motel Paid for without emergency shelter voucher Jail, prison or juvenile detention facility Long-term care facility or nursing home Moved from one HOPWA funded project to HOPWA PH Moved from one HOPWA funded to HOPWA TH Owned by client, no ongoing housing subsidy Permanent housing (other than RRH) for formerly homeless persons |  Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/airport or anywhere outside) Psychiatric hospital or other psychiatric facility Rental by client, no ongoing housing subsidy Rental by client, with RRH or equivalent subsidy Rental by client, with VASH housing subsidy Rental by client with GPD TIP housing subsidy Rental by client, with other ongoing housing subsidy Residential project or halfway house with no homeless criteria Safe Haven Staying or living with family, permanent tenure Staying or living with family, temporary tenure (e.g., room, apartment or house) Staying or living with friends, permanent tenure Staying or living with friends, temporary tenure (e.g., room, apartment or house) Substance abuse treatment facility or detox center Transitional housing for homeless persons (including homeless youth) Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ No exit interview completed Client Doesn’t Know Client Refused |

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| **Complete Housing Move-In Date When Client Moves Into a Permanent Housing Unit** |
| **Housing Move-In Date** |  / /  |

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| **Disabling Conditions and Barriers** |
| **Does the client have a disabling condition?** |  Yes No |  Client Doesn’t Know  Client Refused |
| **If Yes, please complete the following for each disability type** |
| **Alcohol Abuse**  Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently.  |  Yes  No Client Doesn’t Know Client Refused |
| **Drug Abuse**  Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Both Alcohol & Drug Abuse** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, If the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Chronic Health Condition** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Developmental Disability** Yes  No Client Doesn’t Know Client Refused | Substantially Impairs Independence?If Yes, Expected to substantially impair ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |

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| **Disabling Conditions and Barriers** |
| **Physical Disability** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **HIV - AIDS**  Yes  No Client Doesn’t Know Client Refused | If Yes, Substantially Impairs Independence?Expected to substantially impair ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Mental Health Problem** Yes  No Client Doesn’t Know Client Refused | Condition Long Term?If Yes, if the problem is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. |  Yes  No Client Doesn’t Know Client Refused |
| **Domestic Violence Victim/Survivor** Yes  No Client Doesn’t Know Client Refused | Last Occurrence?If Yes, How long ago did the person have the most recent experience? |  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 |
| **Are You Currently Fleeing?** | Are you currently fleeing domestic violence? |  Yes  No Client Doesn’t Know Client Refused |

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| **Monthly Income – Cash Benefits** |
| **Income from any source?** | Yes No Client doesn’t know Client refused |
|  Earned Income $  Unemployment Insurance $  Worker’s Compensation $  Private Disability Insurance $  VA Service-Connected Disability Pension$  Social Security Disability InsuranceSSDI $  |  Supplemental Security Income SSI $  Retirement income from Social Security $  VA Non-service connect disability pension $  Pension or Retirement Income from a Former Job $  Temporary Assistance for Needy Families TANF $  General Assistance (GA) $  Alimony and Other Spousal Support $  Child Support $  Other Cash Income $ If Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| **Total Cash Income for Individual** | **TOTAL**: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Non-Cash Benefits** |
| **Receiving Non-Cash Benefits?** | Yes No Client doesn’t know Client refused |
|  Supplemental Nutrition Assistance Program (SNAP) Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) TANF Childcare Services  |  TANF Transportation Services Other TANF-Funded Services Other Non-Cash BenefitIf Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Health Insurance** |
| **Covered by health insurance?** | Yes No Client doesn’t know Client refused |
|  Medicaid Medicare State Children’s Health Insurance Program Veteran’s Administration (VA) Medical Services Employer-Provided Health Insurance |  Health Insurance Obtained Through COBRA Private Pay Health Insurance State Health Insurance for Adults Indian Health Services Program Other Health InsuranceIf Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |

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| **Employment Status** |
| **Employed** |  Yes No |  Client Doesn’t Know  Client Refused |
| **If Yes, Type of Employment** |  Full-time Part-time Seasonal/Sporadic (including day labor) |
| **If No, Why Not Employed** |  Looking for work Unable to work Not looking for work |  |

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| **Last Grade Completed** |
| **Last Grade Completed** |  Less than Grade 5Grades 5-6Grades 7-8Grades 9-11Grade 12/ High school diplomaSchool program does not have grade levels | GEDSome collegeAssociate’s degreeBachelor’s degreeGraduate degreeVocational certification Client Doesn’t Know  Client Refused |
| **Mental Health Status** |
| **Mental Health Status** | ExcellentVery Good Good Fair | Poor Client Doesn’t KnowClient Refused |

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| **General Health** |
| **General Health** | ExcellentVery Good Good Fair | Poor Client Doesn’t KnowClient Refused |
| **Project Completion Status** |
| **Project Completion Status** | Completed projectYouth voluntarily left early Youth Was expelled or otherwise involuntarily discharged form project. |

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| **SAFE AND APPROPRIATE EXIT** |
| **Ext destination safe – as determined by the client** |  Yes No |  Client Doesn’t Know  Client Refused |
| **Ext destination safe – as determined by the project/caseworker**  |  Yes No Worker doesn’t know |
| **Client has permanent positive adult connections outside of project** |  Yes No Worker doesn’t know |  |
| **Client has permanent positive peer connections outside of project** |  Yes No Worker doesn’t know |  |
| **Client has permanent positive community connections outside of project** |  Yes No Worker doesn’t know |  |

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| **Contact Information** [Optional – can be entered in Location Tab] |
| **Phone Number** |  |
| **Email** |  |
| **Current Address (if applicable)** |  |
|  **City** |  |
| **State** |  |  | **Zip Code** |

I, (Adult client or Head of Household) certify that the information I have provided here is true/correct to the best of my knowledge.

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| Print Name of Client | Signature of Client | Date |
| Print Name of Intake Worker | Signature of Intake Worker | Date |