

HMIS # _____ CM Name: _____ Project Entry Date: ____/____/____
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Santa Barbara County HMIS Standard Exit

This form is designed to be completed by a service provider while interviewing a client.
 A separate Standard Intake form should be completed for each member of the

Household Information

Is the client: Single Adult Adult in Household

If Adult Household is checked:

Are you the Head of Household (HOH)? Yes No | If No, Name of HOH: _____

How many adults are in the household? _____ | How many children are in the household? _____

If you are in a household, what is your relationship to the HoH?

- Self (head of household)
 Head of household's child
 Head of household's spouse or partner
 Other: relation to head of household
 Other: non-relation member

Client Profile

First Name: _____ Middle Name: _____ Last Name: _____

Social Security Number: ____ - ____ - _____

U.S. Military Veteran? Yes No Client Doesn't Know Client Refused

Reason for Leaving & Destination

Reason for Leaving:

- Completed program
- Criminal activity / violence
- Death
- Disagreement with rules/persons
- Left for housing opp. before completing program
- Needs could not be met
- Non-compliance with program
- Non-payment of rent
- Other
- Reached maximum time allowed
- Unknown/Disappeared

Destination:

Homeless Situation:

- Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside) (HUD)
- Emergency shelter, incl. hotel/motel paid for w/ ES voucher, or RHY-funded Host Home shelter (HUD)
- Safe Haven (HUD)

Institutional Situation

- Foster care home or foster care group home (HUD) | Hospital or other residential non-psychiatric medical facility (HUD)
- Jail, prison or juvenile detention facility (HUD) | Long-term care facility or nursing home (HUD)
- Psychiatric hospital or other psychiatric facility (HUD) | Substance abuse treatment facility or detox center (HUD)

Temporary & Permanent Housing Situation

- Residential project or halfway house with no homeless criteria (HUD) | Hotel or motel paid for without emergency shelter voucher (HUD)
- Transitional housing for homeless persons (including homeless youth) (HUD) | Host Home (non-crisis) (HUD)
- Staying or living with friends, temporary tenure (HUD) | Staying or living with family, temporary tenure (HUD)
- Staying or living with family, permanent tenure (HUD) | Staying or living with friends, permanent tenure (HUD)
- Moved from one HOPWA funded project to HOPWA PH (HUD) | Moved from one HOPWA funded project to HOPWA TH (HUD)
- Rental by client, with GPD TIP housing subsidy (HUD) | Rental by client, with VASH housing subsidy (HUD)
- Permanent housing (other than RRH) for formerly homeless persons (HUD) | Rental by client, with RRH or equivalent subsidy (HUD)
- Rental by client, with HCV voucher (tenant or project based) (HUD) | Rental by client in a public housing unit (HUD)
- Rental by client, no ongoing housing subsidy (HUD) | Rental by client, with other ongoing housing subsidy (HUD)
- Owned by client, with ongoing housing subsidy (HUD) | Owned by client, no ongoing housing subsidy (HUD)

OTHER

- No exit interview completed (HUD)
- Other HUD
- Deceased (HUD)
- Client doesn't know (HUD)
- Client refused (HUD)
- Data not collected (HUD)

Housing Move-in Date: ____/____/____

Monthly Income - Cash Benefits

Income from any source?

Yes | No | Client doesn't know | Client refused || Total Monthly Income: \$_____

Types of Income (Check if any)	Income Source Amount	Date start receiving:
<input type="checkbox"/> Alimony or Other Spousal Income (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Child Support (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Earned Income (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> General Assistance (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Other (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Pension or retirement from another job (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Private disability insurance (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Retirement income from Social Security (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> SSDI (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> SSI (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> TANF (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Unemployment Insurance (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> VA Non-service connect disability pension (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> VA Service connected disability compensation (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Worker's Compensation (HUD)	\$_____	_____/_____/_____

Non-Cash Benefits

Non-cash benefit from any source? Yes | No | Client doesn't know | Client refused

Types of Non-Cash Benefits (Check if any)	Income Source Amount	Date start receiving:
<input type="checkbox"/> Supplemental nutrition assistance program (Food Stamps) (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Special supplement nutrition program for WIC (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> TANF-Child care services (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> TANF Transportation services (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Other TANF funded services (HUD)	\$_____	_____/_____/_____
<input type="checkbox"/> Other Source (HUD)	\$_____	_____/_____/_____

If Other, please specify:

Health Insurance

Covered by Health Insurance? Yes | No | Client doesn't know | Client refused

Types of Health Insurance (Check if any)	Start Date receiving:
<input type="checkbox"/> Employer provided Health Insurance	____/____/____
<input type="checkbox"/> Health Insurance Obtained through COBRA	____/____/____
<input type="checkbox"/> Indian health services program	____/____/____
<input type="checkbox"/> Medicare	____/____/____
<input type="checkbox"/> Medicaid	____/____/____
<input type="checkbox"/> Private pay health plan	____/____/____
<input type="checkbox"/> State children's health insurance program	____/____/____
<input type="checkbox"/> State health insurance for adults	____/____/____
<input type="checkbox"/> VA Medical Services	____/____/____
<input type="checkbox"/> Other Source	____/____/____

If Other, please specify:

Disability

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

Disability Type / Disability Determination:

Alcohol Abuse (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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

Both Alcohol and Drug use disorders (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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

Chronic Health Condition (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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 (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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

Disability (Continued)

Drug use disorder(HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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 (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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

Mental Health Disorder(HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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 Data not collected

Physical (HUD): _____

Yes No Client Doesn't Know Client Refused

Disability Start Date: ____/____/____

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

Permanent Supportive Housing Programs Only

Well-Being

Client perceives their life has value and worth.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree Client doesn't know Client refused

Client perceives they have support from others who will listen to problems.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree Client doesn't know Client refused

Client perceives they have a tendency to bounce back after hard times.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree Client doesn't know Client refused

Client's frequency of feeling nervous,tense,worried,frustrated,or afraid.

Strongly disagree Somewhat disagree Neither agree nor disagree Somewhat agree Strongly agree Client doesn't know Client refused

General Health Excellent Very good Good Fair Poor Client doesn't know Client refused

Moving on Assistance Provided: Date: ____/____/____

Subsidized housing application assistance | Financial assistance for Moving On (e.g., security deposit, moving expenses) | Non-financial assistance for Moving On (e.g., housing navigation, transition support) | Housing referral/placement Other(please specify):_____

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

Print Name of Client

Signature of Client

Date

Print Name of Intake Worker

Signature of Intake Worker

Date