Name/Identification:

Legal First Name: _____ Middle Name: _____

Legal Last Name: _____ Suffix: _____

Date of Birth: _____ SSN: _____

Destination and Reason for Leaving (All fields required unless otherwise noted)

Destination (Check only one)
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 project to HOPWA TH
Owned by client, no ongoing housing subsidy
Owned by client, with ongoing housing subsidy
Permanent supportive housing for formerly homeless persons (such as: CoC project; or HUD legacy programs; or HOPWA PH)
Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
Psychiatric hospital or other psychiatric facility
Rental by client, no ongoing housing subsidy
Rental by client, with VASH housing subsidy
Rental by client, with GPD TIP housing subsidy
Rental by client, 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
Data not Collected

Reason for Leaving (Check only one)	
Left for a housing opportunity before completing program	Needs could not be met by program
Completed program	Disagreement with rules/persons
Non-payment of rent/occupancy charge	Death
Non-compliance with program	Unknown/disappeared
Criminal activity/destruction of property/violence	Other
Reached maximum time allowed by program	

Destination Address (optional)		
Street Address:		Unit #:
City:		County:
State:	Zip: _____-_____	Country:
Email:	Phone:	Alt Phone:

***Income and Insurance** (All fields required unless otherwise noted)*

Income Source (Check all that apply):	Stated Income:	Pay Interval:					
		Weekly	Every Other Week	Twice A Month	Monthly	Quarterly	Yearly
No financial resources							
Earned Income *(employment wages / cash)*							
Unemployment Insurance							
Supplemental Security Income (SSI)							
Social Security Disability Income (SSDI)							
VA Service-Connected Disability Compensation							
VA Non-Service-Connected Disability Pension							
Private Disability Insurance							
Workers Compensation							
Temporary Assistance for Needy Families *(CalWORKs)*							
General Assistance (GA) *(General Relief (GR))*							
Retirement Income from Social Security							
Pension or retirement income from a former job							
Child Support							
Alimony or other spousal support							
Other Source (Specify:_____)							
Client Doesn't Know							
Client Refused							
Data not Collected							

Income Documentation (Optional):			Comments (Optional):
GR Form	CalWORKS Forms	Pension Letter/Stub	
Pay Stub	Unemployment Insurance Forms	Unemployment Forms	
Utility Allowance	W-2 Forms	Self Declaration	
Child Support Forms	SSDI Form	Employer Printout/Letter	
Social Security Forms	Workmans Comp	VA Documentation	
SSI Forms	Self Employment Docs		

Non-Cash Benefits (Check all that apply):			
None	Client Doesn't Know	Client Refused	Data not Collected
Food Stamps (CalFresh)	CalWorks Child Care	Temporary Rental Assistance	
Amount: _____	CalWorks Transportation	Section 8 or Rental Assistance	Medically Needy
WIC	Other CalWorks-Funded Services	Other _____	Amount: _____

Health Insurance (Check all that apply):			
No Health Insurance	Employer Provided Health Ins.		COBRA Health Ins.
MediCal		Client Doesn't Know	
		MEDICARE	

Client Refused	Data not Collected
State Children's Health Ins. Private Health Ins.	VA Medical Services

Other_____ Indian Health Services Program

Program Exit: Program
Name:_____ _____

Case Manager: _____ Program Exit Date: ____/____/____

***WELLNESS** – All clients, required questions are shaded*

Question	Check One Answer	Comments
Do you have a physical disability?	Yes No Client Doesn't Know Client Refused Data not Collected	
Physical Disability: Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Physical Disability: Documentation of the disability and severity on file (Required if physical disability is Yes)	Yes No	
If yes, are you currently receiving services or treatment for this condition? (Required if physical disability is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Do you have a developmental disability?	Yes No Client Doesn't Know Client Refused Data not Collected	
Developmental Disability: Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Developmental Disability: Documentation of the disability and severity on file (Required if developmental disability is Yes)	Yes No	
If yes, are you currently receiving services or treatment for this condition? (Required if developmental disability is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Have you been diagnosed with AIDS or have you tested positive for HIV?	Yes No Client Doesn't Know Client Refused Data not Collected	
HIV/AIDS: Expected to substantially impair ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
HIV/AIDS: Documentation of the disability and severity on file (Required if HIV/AIDS is Yes)	Yes No	

If yes, are you currently receiving services or treatment for this condition?	Yes No Client Doesn't Know	

(Required if HIV/AIDS is Yes)	Client Refused Data not Collected	
Do you feel you have a mental health problem?	Yes No Client Doesn't Know Client Refused Data not Collected	
Mental Health: Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Mental Health: Documentation of the disability and severity on file (Required if mental health is Yes)	Yes No	
If yes, are you currently receiving services or treatment for this condition? (Required if mental health is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Mental Health: If yes for condition, how confirmed? (Required if mental health is Yes)	Unconfirmed; presumptive or self-report Confirmed through assessment and clinical evaluation Confirmed by prior evaluation or clinical records	
Mental Health: Serious mental illness (SMI), and if SMI, how confirmed? (Required if mental health is Yes)	No Unconfirmed; presumptive or self-report Confirmed through assessment and clinical evaluation Confirmed by prior evaluation or clinical records Client Doesn't Know Client Refused	
Do you have a drug or alcohol problem?	Drug Alcohol Both No Client Doesn't Know Client Refused Data not Collected	
Substance Abuse: Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Substance Abuse: Documentation of the disability and severity on file (Required if substance abuse is Yes)	Yes No	
If yes, are you currently receiving services or treatment for this condition? (Required if substance abuse is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	

Substance Abuse: If yes for condition, how confirmed? (Required if substance abuse is Yes)	Unconfirmed; presumptive or self-report Confirmed through assessment and clinical evaluation Confirmed by prior evaluation or clinical records	

Chronic Health Condition	Yes No Client Doesn't Know Client Refused Data not Collected	
Chronic Health Condition: Expected to be of long–continued and indefinite duration and substantially impairs ability to live independently (Required if previous question is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	
Chronic Health Condition: Documentation of the disability and severity on file (Required if chronic health condition is Yes)	Yes No	
If yes, are you currently receiving services or treatment for this condition? (Required if chronic health condition is Yes)	Yes No Client Doesn't Know Client Refused Data not Collected	

EMPLOYMENT: *For adults18 and older or Head of Household < 18 years old, required questions shaded*

Question	Check One Answer	Comments
Are you currently employed?	No Yes Client Doesn't Know Client Refused	
If Yes for 'Employed', Type of Employment: (Required if currently employed is 'Yes')	Full-time Part-time Seasonal / sporadic (including day labor)	
If No for 'Employed', Why Not Employed (Required if currently employed is 'No')	Looking for work Not looking for work Unable to work	

PATH Questions: *Required for PATH-Funded Clients ONLY*

Connection with SOAR	Yes No Client Doesn't Know Client Refused Data not Collected	

Client Signature _____ Site _____ Date _____

Agency Staff Signature _____ Site _____ Date _____

DO NOT WRITE IN BOX BELOW – DATA ENTRY PERSONNEL ONLY (Optional):

Date entered into HMIS: ____/____/_____

Question	Answer	Initials of Staff completion	Comments
Was the hard copy exit form completely filled out correctly?	Yes No		

Staff Name (verifying completion of Data Entry): _____

Client Name / ID: _____