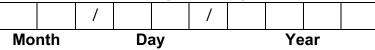Agency Name: _____

CLARITY
HUMAN SERVICES

San Francisco ONE System: HHS-PATH PROJECT EXIT FORM
Use block letters for text and bubble in the appropriate circles.
Please complete a separate form for each household member.

CLIENT NAME OR IDENTIFIER:_____

PROJECT EXIT DATE *[All Clients]*

		/			/				

Month   **Day**   **Year**

DESTINATION *[All Clients]*

○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside)	○	Staying or living with family, permanent tenure
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter	○	Staying or living with friends, permanent tenure
○	Safe Haven	○	Moved from one HOPWA funded project to HOPWA PH
○	Foster care home or foster care group home	○	Moved from one HOPWA funded project to HOPWA TH
○	Hospital or other residential non-psychiatric medical facility	○	Rental by client, no ongoing housing subsidy
○	Jail, prison or juvenile detention facility	○	Rental by client, with ongoing housing subsidy
○	Long-term care facility or nursing home	○	Owned by client, with on-going housing subsidy
○	Psychiatric hospital or other psychiatric facility	○	Owned by client, no on-going housing subsidy
○	Substance abuse treatment facility or detox center	○	Permanent housing (other than RRH) for formerly homeless persons
○	Transitional housing for homeless persons (including homeless youth)	○	No exit interview completed
○	Residential project or halfway house with no homeless criteria	○	Other (specify):
○	Hotel or motel paid for without emergency shelter voucher	○	Deceased
○	Host Home (non-crisis)	○	Client doesn't know
○	Staying or living in a friend's room, apartment, or house	○	Client prefers not to answer
○	Staying or living in a family member's room, apartment or house	○	Data not collected
○	Moved from one HOPWA funded project to HOPWA TH	○	Specify Other Exit Destination:
IF "RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY" – SPECIFY:			
○	GPD TIP housing subsidy	○	Emergency Housing Voucher
○	VASH Housing subsidy	○	Family Unification Program Voucher (FUP)
○	RRH or equivalent subsidy	○	Foster Youth to Independence Initiative (FYI) Permanent Supportive Housing Other permanent housing dedicated for formerly homeless persons
○	HCV voucher (tenant or project based) (not dedicated)	○	Permanent Supportive Housing
○	Public Housing Unit	○	

○	Rental by client, with other ongoing housing subsidy		Other permanent housing dedicated for formerly homeless persons

PATH STATUS *[If not at intake]*

Date of Status Determination	○	___/_____/____
Client Became Enrolled in PATH	○	No
	○	Yes
IF "NO" TO ENROLLED IN PATH		
Reason Not Enrolled	○	Client was found ineligible for PATH
	○	Client was not enrolled for other reason(s)
	○	Unable to locate client

CONNECTION WITH SOAR *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

DISABLING CONDITION [All Clients]

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

PHYSICAL DISABILITY *[All Clients]*

○	No			○	Client doesn't know
○	Yes			○	Client prefers not to answer
				○	Data not collected
IF "YES" TO PHYSICAL DISABILITY – SPECIFY					
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know	
	○	Yes	○	Client prefers not to answer	
			○	Data not collected	

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No			○	Client doesn't know
○	Yes			○	Client prefers not to answer
				○	Data not collected
IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY					
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know	
	○	Yes	○	Client prefers not to answer	
			○	Data not collected	

CHRONIC HEALTH CONDITION *[All Clients]*

○	No			○	Client doesn't know
○	Yes			○	Client prefers not to answer
				○	Data not collected
IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY					
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know	
	○	Yes	○	Client prefers not to answer	
			○	Data not collected	

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer

		○	Data not collected

IF "YES" TO HIV-AIDS – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client prefers not to answer
			○	Data not collected

MENTAL HEALTH DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO MENTAL HEALTH DISORDER – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client prefers not to answer
			○	Data not collected

SUBSTANCE USE DISORDER *[All Clients]*

○	No	○	Client doesn't know
○	Alcohol use disorder	○	Client prefers not to answer
○	Drug use disorder	○	Data not collected
○	Both alcohol and drug use disorders		

IF "ALCOHOL USE DISORDER" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDERS" – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client prefers not to answer
			○	Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

Income Source		Amount	Income Source		Amount
○	Earned Income		○	CalWORKS	
○	Unemployment Insurance		○	CAAP	
○	Supplemental Security Income (SSI)		○	Retirement income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or retirement income from a former job	
○	VA Service-Connected Disability Compensation		○	Child support	
○	VA Non-Service-Connected Disability Pension		○	Alimony and other spousal support	
○	Private disability insurance		○	Other income source *(specify):*	
○	Worker's Compensation				

Total Monthly Income for Individual:

RECEIVING NON-CASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	CalFresh	○	CalWORKs Child Care Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	CalWORKs Transportation Services
○	Other (specify):	○	CalWORKs TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client prefers not to answer
		○	Data not collected
IF "YES" TO HEALTH INSURANCE – HEALTH INSURANCE COVERAGE DETAILS			
○	Medi-Cal	○	Employer Provided Health Insurance
○	MEDICARE	○	Health Insurance Obtained Through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Health Administration (VHA)	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

CONTACT INFORMATION *[Optional – can be entered in Contact Tab]*

Contact Type										
Email										
Phone (#1)										
Phone (#2)										
Active Contact	○	Yes			○	No				
Private	○	Yes			○	No				
Contact Date										
Note										

CURRENT ADDRESS (IF APPLICABLE) *[Optional – can be entered in Location Tab]*

Street			
City			
Street		**Zip Code**	

_____

Signature of applicant stating all information is true and correct   Date