

Agency Name: _____



San Francisco ONE System: HUD-CoC 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]*

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

HOUSING ASSESSMENT AT EXIT [HOMELESS PREVENTION ONLY]

<input type="radio"/>	Able to maintain the housing they had at project entry	<input type="radio"/>	Client became homeless – moving to a shelter or other place unfit for human habitation
<input type="radio"/>	Moved to new housing unit		
<input type="radio"/>	Moved in with family/friends on a temporary basis	<input type="radio"/>	Client went to jail/prison
		<input type="radio"/>	Client died
<input type="radio"/>	Moved in with family/friends on a permanent basis	<input type="radio"/>	Client doesn't know
		<input type="radio"/>	Client refused
<input type="radio"/>	Moved to a transitional or temporary housing facility or program	<input type="radio"/>	Data not collected

IF “ABLE TO MAINTAIN HOUSING AT PROJECT ENTRY” TO HOUSING ASSESSMENT
Subsidy Information

<input type="radio"/>	Without a subsidy	<input type="radio"/>	With an ongoing subsidy acquired since project entry
<input type="radio"/>	With the subsidy they had at project entry	<input type="radio"/>	Only with financial assistance other than a subsidy

IF “MOVED TO NEW HOUSING UNIT” TO HOUSING ASSESSMENT
Subsidy Information

<input type="radio"/>	With ongoing subsidy	<input type="radio"/>	Without an ongoing subsidy
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IN PERMANENT HOUSING [Permanent Housing Projects, for Heads of Households]

<input type="radio"/>	No	<input type="radio"/>	Yes
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IF “YES” TO PERMANENT HOUSING

Housing Move-in Date	___/___/_____
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DISABLING CONDITION [All Clients – if ‘yes’ to any condition, mark ‘yes’]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

PHYSICAL DISABILITY [All Clients]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	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?	<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
	<input type="radio"/>	Yes	<input type="radio"/>	Client refused
			<input type="radio"/>	Data not collected

DEVELOPMENTAL DISABILITY [All Clients]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY

Expected to substantially impair ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

CHRONIC HEALTH CONDITION [All Clients]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> 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?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

HIV-AIDS [All Clients]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

IF "YES" TO HIV-AIDS – SPECIFY

Expected to substantially impair ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

MENTAL HEALTH PROBLEM [All Clients]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

IF "YES" TO MENTAL HEALTH PROBLEMS – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

SUBSTANCE ABUSE PROBLEM [All Clients]

<input type="radio"/> No	<input type="radio"/> Both alcohol & drug abuse
<input type="radio"/> Alcohol abuse	<input type="radio"/> Client doesn't know
	<input type="radio"/> Client refused
<input type="radio"/> Drug abuse	<input type="radio"/> Data not collected

IF “ALCOHOL ABUSE” “DRUG ABUSE” OR “BOTH ALCOHOL AND DRUG ABUSE”– SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused

DOMESTIC VIOLENCE VICTIM/SURVIVOR [Head of Household and Adults]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

IF “YES” TO DOMESTIC VIOLENCE-WHEN EXPERIENCED OCCURRED

<input type="radio"/> Within the past three months	<input type="radio"/> One year ago or more	
<input type="radio"/> Three to six months ago (excluding six months exactly)	<input type="radio"/> Client doesn't know	
	<input type="radio"/> Client refused	
<input type="radio"/> Six months to one year ago (excluding one year exactly)	<input type="radio"/> Data not collected	
Are you currently fleeing?	<input type="radio"/> No	<input type="radio"/> Client doesn't know
	<input type="radio"/> Yes	<input type="radio"/> Client refused
		<input type="radio"/> Data not collected

INCOME FROM ANY SOURCE [Head of Household and Adults]

<input type="radio"/> No	<input type="radio"/> Client doesn't know
<input type="radio"/> Yes	<input type="radio"/> Client refused
	<input type="radio"/> Data not collected

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

Income Source	Amount	Income Source	Amount
<input type="radio"/> Alimony and Other Spousal Support		<input type="radio"/> Child support	
<input type="radio"/> Pension or Retirement income from former job		<input type="radio"/> Earned Income	
<input type="radio"/> Retirement Income from Social Security		<input type="radio"/> CAAP	
<input type="radio"/> Social Security Disability Insurance (SSDI)		<input type="radio"/> Private Disability Insurance	
<input type="radio"/> Supplemental Security Income (SSI)		<input type="radio"/> Unemployment Insurance	
<input type="radio"/> CalWORKs		<input type="radio"/> Worker's Compensation	
<input type="radio"/> VA Service Connected Disability Compensation		<input type="radio"/> Other Cash Income	
<input type="radio"/> VA Non-Service Connected Disability Pension		Other Cash Income Source (specify):	

Total Cash Income for Individual (monthly amount):

RECEIVING NONCASH BENEFITS [*Head of Household and Adults*]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY

<input type="radio"/>	CalFresh	<input type="radio"/>	CalWORKs Childcare Services
<input type="radio"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="radio"/>	CalWORKs Transportation Services
<input type="radio"/>	Other Non-Cash Benefit (Specify Source):	<input type="radio"/>	Other CalWORKs-funded services

COVERED BY HEALTH INSURANCE [*All Clients*]

<input type="radio"/>	No	<input type="radio"/>	Client doesn't know
<input type="radio"/>	Yes	<input type="radio"/>	Client refused
		<input type="radio"/>	Data not collected

IF "YES" TO HEALTH INSURANCE HEALTH INSURANCE COVERAGE DETAILS

<input type="radio"/>	Medi-Cal	<input type="radio"/>	Employer Provided Health Insurance
<input type="radio"/>	MEDICARE	<input type="radio"/>	Health Insurance Obtained through COBRA
<input type="radio"/>	State Children's Health Insurance (SCHIP)	<input type="radio"/>	Private Pay Health Insurance
<input type="radio"/>	Veteran's Administration (VA) Medical Services	<input type="radio"/>	State Health Insurance for Adults
<input type="radio"/>	Other Health Insurance (Specify Source):	<input type="radio"/>	Indian Health Services Program

CONTACT INFORMATION

Contact Type:				
Email:				
Phone (#1):				
Phone (#2):				
Active Contact:	<input type="radio"/>	Yes	<input type="radio"/>	No
Private:	<input type="radio"/>	Yes	<input type="radio"/>	No
Contact Date:				
Note:				