

CLARITY HMIS: UPLIFT 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:_____



DESTINATION [All Clients]

0	Deceased	0	Rental by client, with RRH or equivalent subsidy
0	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	0	Rental by client, with VASH housing subsidy
0	Foster care home or foster care group home	0	Rental by client, with GPD TIP housing subsidy
0	Hospital or other residential non-psychiatric medical facility	0	Rental by client, with other ongoing housing subsidy
0	Hotel or motel paid for without emergency shelter voucher	0	Residential project or halfway house with no homeless criteria
0	Jail, prison or juvenile detention facility	0	Safe Haven
0	Long-term care facility or nursing home	0	Staying or living with family, permanent tenure
0	Moved from one HOPWA funded project to HOPWA PH	0	Staying or living with family, temporary tenure (e.g., room, apartment or house)
0	Moved from one HOPWA funded project to HOPWA TH	0	Staying or living with friends, permanent tenure
0	Owned by client, no ongoing housing subsidy	0	Staying or living with friends, temporary tenure (e.g., room, apartment or house)
0	Owned by client, with ongoing housing subsidy	0	Substance abuse treatment facility or detox center
0	Permanent housing (other than RRH) for formerly homeless persons	0	Transitional housing for homeless persons (including homeless youth)
	Place not meant for habitation (e.g., a vehicle, an	0	Other (specify):
0	abandoned building, bus/train/airport or anywhere outside)	0	No exit interview completed
		0	Client doesn't know
0	Psychiatric hospital or other psychiatric facility	0	Client refused
0	Rental by client, no ongoing housing subsidy	0	Data not collected



DISABLING CONDITION [All Clients - if 'yes' to any condition, mark 'yes']

0	No	0	Client doesn't know
-	Yes	0	Client refused
0		0	Data not collected

PHYSICAL DISABILITY [All Clients]

0	No			0	Client doesn't know	
	No.		Var		0	Client refused
0	• Yes				Data not collected	
IF "ነ	IF "YES" TO PHYSICAL DISABILITY – SPECIFY					
Expected to be of long-continued and indefinite ouration and substantially impairs ability to live		0	No	0	Client doesn't know	
			Yes	0	Client refused	
inde	ependently?	0	165	0	Data not collected	

DEVELOPMENTAL DISABILITY [All Clients]

0	• No			0	Client doesn't know	
	Vez		No.		0	Client refused
0	Yes			0	Data not collected	
IF "Y	IF "YES" TO DEVELOPMENTAL DISABILITY – SPECIFY					
Expected to substantially impair ability to live independently?		0	No	0	Client doesn't know	
			Vaa	0	Client refused	
inue	pendentiy:	0	Yes	0	Data not collected	

CHRONIC HEALTH CONDITION [All Clients]

0	No			0	Client doesn't know
Ver			0	Client refused	
0	• Yes			0	Data not collected
IF "	YES" TO CHRONIC HEALTH CONDITION - SPEC	IFY			
		0	No	0	Client doesn't know
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		Vaa	0	Client refused	
anu		0	Yes	0	Data not collected

HIV-AIDS [All Clients]

0	No			0	Client doesn't know
	Voo			0	Client refused
0				0	Data not collected
IF "YES" TO HIV-AIDS – SPECIFY					
Expected to substantially impair ability to live independently?		0	No	0	Client doesn't know
			Yes	0	Client refused
inde	pendentiy:	0	res	0	Data not collected



MENTAL HEALTH PROBLEM [All Clients]

0	• No				Client doesn't know
	Vaa			0	Client refused
0				0	Data not collected
IF "`	YES" TO MENTAL HEALTH PROBLEMS – SPECI	FY			
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently		0	No	0	Client doesn't know
			Vaa	0	Client refused
anu	substantially impairs ability to live independently		Yes	0	Data not collected

SUBSTANCE ABUSE PROBLEM [All Clients]

0	No			0	Both alcohol & drug abuse	
				0	Client doesn't know	
 Alcohol abuse 				0	Client refused	
0	Drug abuse			0	Data not collected	
IF ".	IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE"- SPECIFY					
Expected to be of long-continued and indefinite duration \circ No			0	Client doesn't know		
and substantially impairs ability to live independently? \bigcirc		0	Yes	0	Client refused	

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

0	No			0	Client doesn't know
	N N		0	Client refused	
0	Yes			0	Data not collected
IF "	YES" TO DOMESTIC VIOLENCE				
WH	EN EXPERIENCE OCCURRED				
0	Within the past three months			0	One year ago or more
	Three to giv months ago (avaluding giv months av	o othy)		0	Client doesn't know
0	Three to six months ago (excluding six months ex	acuy)		0	Client refused
0	Six months to one year ago (excluding one year e	xactly)	0	Data not collected
	you currently fleeing?	0	No	0	Client doesn't know
Are		0	N	0	Client refused
			Yes	0	Data not collected

INCO

ME FROM ANY SOURCE [Head of Household and Adults]

0	No	0	Client doesn't know			
	Yes	0	Client refused			
0		0	Data not collected			
IF "	IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					



Inco	ome Source	Amount	nount Income Source		
0	Alimony and Other Spousal Support		0	Child support	
0	Pension or Retirement income from former j	ob	0	Earned Income	
0	Retirement Income from Social Security		0	General Assistance (GA)	
0	Social Security Disability Insurance (SSDI)		0	Private Disability Insurance	
0	Supplemental Security Income (SSI)		0	Unemployment Insurance	
0	TANF (Temporary Assist for Needy Families)	0	Worker's Compensation	
0	VA Service Connected Disability Compensation		0	Other source	
0	VA Non-Service Connected Disability Pension	on	Other	r (specify):	
Tota	I monthly amount:				

RECEIVING NONCASH BENEFITS [Head of Household and Adults]

0	No				Client doesn't know		
	No			0	Client refused		
0	Yes			0	Data not collected		
IF "Y	IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY						
0	Supplemental Nutrition Assistance Program (SNAP)	0	TANF Childcare Services				
0	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	0	TANF Transportation Services				
0	Other (Specify):	0	Other TANF-funded services				

COVERED BY HEALTH INSURANCE [All Clients]

0	No	0	Client doesn't know									
0	Yes	0	Client refused									
0	165	0	Data not collected									
IF "	IF "YES" TO HEALTH INSURANCE HEALTH INSURANCE COVERAGE DETAILS											
0	MEDICAID	0	Employer Provided Health Insurance									
0	MEDICARE	0	Insurance Obtained through COBRA									
0	State Children's Health Insurance (SCHIP)	0	Private Pay Health Insurance									
0	Veteran's Administration (VA) Medical Services	0	State Health Insurance for Adults									
0	Other (specify)	0	Indian Health Services Program									

CONTACT INFORMATION [Optional- can be entered in Location Tab]

Phone Number									
Email									



Current Address (if applicable)											
Street											
City											
State							Zip Code				

Signature of applicant stating all information is true and correct Date