**CLARITY HMIS: KC- 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:** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

# **PROGRAM EXIT DATE**​ [All Individual/Clients]

|   |  |  *­*  |  |  |  *­*  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |

 Month DayYear

# **DESTINATION** [All Clients]

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

| **\*If Destination is “Place not meant for habitation”** |
| --- |
| **Is household’s destination living situation in a vehicle?** | **○** | No  | ○ | Client doesn’t know  |
| **○** | Yes  | ○ | Client prefers not to answer  |
| ○ | Data not collected  |
| If “Yes”, please select Vehicle type |
| ○ | Van | ○ | Client Doesn't Know |
| ○ | Automobile/Car | ○ | Client prefers not to answer  |
| ○ | Camper/RV | ○ | Data Not Collected  |

| **If Destination is permanent housing** |
| --- |

# **CITY OF PERMANENT HOUSING LOCATION**

| ○ | Unincorporated King County (includes any community not otherwise listed) | ○ | Medina |
| --- | --- | --- | --- |
| ○ | Algona | ○ | Mercer Island |
| ○ | Auburn | ○ | Milton |
| ○ | Beaux Arts | ○ | Newcastle |
| ○ | Bellevue | ○ | Normandy Park |
| ○ | Black Diamond | ○ | North Bend |
| ○ | Bothell | ○ | Pacific |
| ○ | Burien | ○ | Redmond |
| ○ | Carnation | ○ | Renton |
| ○ | Clyde Hill | ○ | Sammamish |
| ○ | Covington | ○ | Sea Tac |
| ○ | Des Moines | ○ | Seattle |
| ○ | Duvall | ○ | Shoreline |
| ○ | Enumclaw | ○ | Skykomish |
| ○ | Federal Way | ○ | Snoqulamie |
| ○ | Hunts Point | ○ | Tukwila |
| ○ | Issaquah | ○ | Woodinville |
| ○ | Kenmore | ○ | Yarrow Point |
| ○ | Kent | ○ | Washington State (outside of King County) |
| ○ | Kirkland  | ○ | Outside of Washington State |
| ○ | Lake Forest Park | ○ | Client Doesn't Know |
| ○ | Maple Valley | ○ | Client prefers not to answer  |
| ○ | Data Not Collected  |

# **HOUSING ASSESSMENT AT EXIT** ​[HOMELESS PREVENTION ONLY ]

| ○ | Able to maintain the housing they had at project entry  | ○ | Client became homeless – moving to a shelter or other place unfit for human habitation |
| --- | --- | --- | --- |
| ○ | Moved to new housing unit  |
| ○ | Moved in with family/friends on a temporary basis  | ○ | Jail/Prison  |
| ○ | Deceased |
| ○ | Moved in with family/friends on a permanent basis  | ○ | Client doesn’t know  |
| ○ | Client prefers not to answer  |
| ○ | Moved to a transitional or temporary housing facility or program  | ○ | Data not collected  |
| **IF “ABLE TO MAINTAIN HOUSING AT PROJECT ENTRY” TO HOUSING ASSESSMENT**  |
| **Subsidy Information**  |
| ○ | Without a subsidy  | ○ | With an on­going subsidy acquired since project entry  |
| ○ | With the subsidy they had at project entry  | ○ | Only with financial assistance other than a subsidy  |
| **IF “MOVED TO NEW HOUSING UNIT” TO HOUSING ASSESSMENT**  |
| **Subsidy Information**  |
| ○ | With on­going subsidy  | ○ | Without an on­going subsidy  |

# **IN PERMANENT HOUSING** ​[Permanent Housing Projects, Head of Household]

| ○ |  No | ○ |  Yes |
| --- | --- | --- | --- |
|  **IF “YES” TO PERMANENT HOUSING** |
|  **Housing Move-In Date:** (See note) \* |  \**If client moved into permanent housing, make sure to update on the* ***enrollment screen****.* |

**DISABLING CONDITION** ​*[All Individuals/Clients]*

*If individual/client is in need of resources, contact the following as appropriate:*

* *For aging or disability support, call the Community Living Connections Line at: 206-962-8467/1-844-348-5464(Toll Free)*
* *For crisis services: Crisis Connections at: 1-866-427-4747,*
* *For mental health or substance use services: King County Behavioral Health Recovery Client Services Line: 1-800-790-8049,*
* *For confidential peer support: Washington Warm Line 1-877-500-WARM(9276).*

**DOES THE INDIVIDUAL/CLIENT HAVE:**

**A PHYSICAL DISABILITY** and/or a **PHYSICAL HEALTH CONDITION** [All Individuals/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  |

**A DEVELOPMENTAL DISABILITY** *[All Individuals/Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client prefers not to answer  |
| ○ | Data not collected  |

**A CHRONIC HEALTH CONDITION** *[All Individuals/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  |

**A MENTAL HEALTH CONDITION** *[All Individuals/Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client prefers not to answer  |
| ○ | 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 | ○ | No  | ○ | Client doesn’t know  |
| ○ | Yes | ○ | Client prefers not to answer  |
| ○ | Data not collected  |

**A SUBSTANCE ABUSE ISSUE** ​*[Head of Household and Adults]*

| ○ | No  | ○ | Both alcohol & drug use disorder |
| --- | --- | --- | --- |
| ○ | Alcohol use disorder  | ○ | Client doesn’t know  |
| ○ | Client prefers not to answer  |
| ○ | Drug use disorder | ○ | Data not collected  |
| **IF “ALCOHOL USE DISORDER” “DRUG USE DISORDER” OR “BOTH ALCOHOL AND DRUG USE 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  |

# **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 |  | ○ | Temporary Assistance for Needy Families (TANF) |   |
| ○ | Unemployment Insurance |  | ○ | General Assistance (GA) |   |
| ○ | 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  |   |
| ○ | 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 NON­CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY**  |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Childcare Services |
| ○ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | ○ | TANF Transportation Services |
| ○ | Other Non-Cash Benefit | ○ | Other TANF-funded services |

**COVERED BY HEALTH INSURANCE** *​[All Individuals/Clients]*

| ○ | No  | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Yes  | ○ | Client prefers not to answer  |
| ○ | Data not collected  |
| **IF “YES” TO HEALTH INSURANCE ­ HEALTH INSURANCE COVERAGE DETAILS**  |
| ○ | MEDICAID  | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE  | ○ | Insurance Obtained through COBRA  |
| ○ | State Children’s Health Insurance (SCHIP)  | ○ | Private Pay Health Insurance  |
| ○ | Veterans Health Administration (VHA) | ○ | State Health Insurance for Adults  |
| ○ | Other (specify) | ○ | Indian Health Services Program |

**CURRENT SCHOOL ENROLLMENT AND ATTENDANCE**​ *[For CoC: YHDP funded programs Head of Household]*

| ○ | Not currently enrolled in any school or educational course | ○ | Client doesn’t know  |
| --- | --- | --- | --- |
| ○ | Currently enrolled but NOT attending regularly (when school or the course is in session) | ○ | Client prefers not to answer |
| ○ | Currently enrolled and attending regularly (when school or the course is in session) | ○ | Data not collected |
|   **IF NOT CURRENTLY ENROLLED, SPECIFY MOST RECENT EDUCATIONAL STATUS:** |
| ○ | K12: Graduated from high school | ○ | Higher education: Dropped out |
| ○ | K12: Obtained GED | ○ | Higher education: Obtained a credential/degree |
| ○ | K12: Dropped out | ○ | Client doesn’t know  |
| ○ | K12: Suspended | ○ | Client prefers not to answer |
| ○ | K12: Expelled | ○ | Data not collected |
| ○ | Higher education: Pursuing a credential but not currently attending |  |  |
|  **IF CURRENTLY ENROLLED, SPECIFY CURRENT EDUCATIONAL STATUS:** |
| ○ | Pursuing a high school diploma or GED | ○ | Pursuing other post-secondary credential |
| ○ | Pursuing Associate’s Degree | ○ | Client doesn’t know  |
| ○ | Pursuing Bachelor’s Degree | ○ | Client prefers not to answer |
| ○ | Pursuing Graduate Degree | ○ | Data not collected |

# 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 NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY**  |
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Child Care Services |
| ○ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | ○ | TANF Transportation Services |
| ○ | Other Non-Cash Benefit | ○ | Other 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** |
| ○ | MEDICAID  | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE  | ○ | Insurance Obtained through COBRA  |
| ○ | State Children’s Health Insurance (SCHIP)  | ○ | Private Pay Health Insurance  |
| ○ | Veterans Administration (VA) Medical Services | ○ | State Health Insurance for Adults  |
| ○ | Other (specify) | ○ | Indian Health Services Program |

***If applicable:***



 **Signature of applicant stating all information is true and correct Date**