

Last Name* _____ **First Name*** _____
Exit Date* _____ **Alias** _____
Project (Program)* _____
Case Worker _____ **Last 4 digits of SSN** _____

HUD Program Data

Exit Destination*

A. HOMELESS SITUATION

- Emergency shelter including hotel or motel paid with emergency shelter voucher or RHY funded Host Home Shelter
- Safe Haven
- Place not meant for habitation – unsheltered, living on th street, beach, part, etc.

B. INSTITUTIONAL SITUATION

- Foster care home or foster care group home
- Hospital or other residential non-psychiatric medical facility
- Jail, prison or juvenile detention facility
- Long-term care facility or nursing home
- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center

C. TEMPORARY HOUSING SITUATION

- Hotel or motel paid for without emergency shelter voucher
- Host home (non-crisis)
- Moved from one HOPWA funded project to HOPWA TH
- Staying or living with family, temporary tenure (e.g., room, apartment or house)
- Staying or living with friends, temporary tenure (e.g., room, apartment or house)
- Transitional housing for homeless persons (including homeless youth)
- Residential project or halfway house with no homeless criteria

D. PERMANENT HOUSING SITUATION

- Staying or living with family, permanent tenure
- Moved from one HOPWA funded project to HOPWA PH
- Rental by client, no ongoing housing subsidy
- Rental by client, ongoing housing subsidy*** (select below):
 - * **Subsidy type:** Housing stability voucher
 - Family unification program voucher (FUP)
 - Foster Youth to Independence Initiative (FYI)
 - HCV voucher (tenant or project based)
 - GIP TPD housing subsidy
 - Other permanent housing dedicated for formerly homeless persons
 - Permanent supportive housing
 - Public housing unit
 - Rental by client, with other ongoing housing subsidy
 - RRH or equivalent
 - VASH housing subsidy
- Staying or living with friends, permanent tenure
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

E. OTHER

- Client doesn't know
- Client prefers not to answer
- Deceased (*Please update the client demographic form with the deceased date)
- No exit interview completed
- Data not collected
- Other _____

Health Insurance*

Are you covered by health insurance?

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

HUD Program Data (Continued)

Disabling Condition

Substance Use Disorder* (If “NO” selected, skip to Mental Health)

- No Drug Use Disorder Both Alcohol and Drug Use Disorder
 Alcohol Use Disorder Client doesn't know Client prefers not to answer Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Mental Health Disorder* (If “NO” selected, skip to Developmental Disability)

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

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Developmental Disability* (If “NO” selected, skip to Chronic Health Condition)

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

Chronic Health Condition* (If “NO” selected, skip to HIV / AIDS)

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

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

HIV / AIDS* (If “NO” selected, skip to Physical Disability) *(as applicable)*

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

Physical Disability* (If “NO” selected, skip to Health Insurance Assessment)

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

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

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

Health Insurance Assessment *(if yes to health insurance)*

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Health Insurance through COBRA |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> State Children's Health Insurance | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> Veteran's Health Administration (VHA) | <input type="checkbox"/> Indian Health Services Program |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Other _____ |