**Agency:** **Exit Date:**

**Program:** **Case Manager:**

**First Name\*:**  **Last Name:**

**Middle Name:** **Suffix:**

**HUD Program Data**

1. ***Exit Destination\****

☐ Place not meant for habitation - unsheltered, living on the street, beach, park, etc.

☐ Emergency shelter including hotel or motel paid with emergency shelter voucher

☐ Safe Haven

☐ Foster care home or foster care group home

☐ Hospital or residential medical facility (non-psychiatric)

☐ 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

☐ Hotel or motel paid for without emergency shelter voucher

☐ Staying or living with family, temporary tenure

☐ Staying or living with friends, temporary tenure

☐ Moved from HOPWA funded project to HOPWA TH

☐ Transitional housing for homeless persons (TH)

☐ Moved from HOPWA funded project to HOPWA PH

☐ Owned by client, no housing subsidy

☐ Owned by client, with housing subsidy

☐ Permanent housing for formerly homeless persons (PH)

☐ Rental by client, GPD TIP housing subsidy

☐ Rental by client, no housing subsidy

☐ Rental by client, other ongoing housing subsidy (Public Housing, low-income housing, Section 8

☐ Rental by client, VASH subsidy

☐ Residential project or halfway house - no homeless criteria

☐ Staying or living with family, permanent tenure

☐ Staying or living with friends, permanent tenure

☐ Other

☐ No exit interview completed

☐ Client doesn't know

☐ Client refused

☐ Data not collected

1. ***Non-Cash Benefits – Current at Exit\****

*Have you received any non-cash benefits in the past 30 days and expect to receive them again next month?*

 ☐ No ☐ Yes ☐Client doesn’t know ☐Client Refused ☐ Data not collected

**If yes, please mark all that are applicable:**

☐ SNAP (Food Stamps) ☐ Other TANF-Funded Services

☐ WIC-Nutrition for Women, Infants, Children ☐ Section 8, Public Housing, Other Ongoing Rental Assistance

☐ TANF Child Care Services ☐ Temporary Rental Assistance

☐ TANF Transportation Services ☐ Other source:

1. ***Health Insurance\****

Are you covered by health insurance?

 ☐ No ☐ Yes ☐Client doesn’t know ☐Client Refused ☐ Data not collected

1. ***Disabling Condition\****

**SUBSTANCE ABUSE\***

 ☐ No ☐ Alcohol Abuse ☐ Drug Abuse

 ☐ Both Alcohol and Drug Abuse ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **How Confirmed\***

☐ Confirmed by prior evaluation or clinical records ☐ Unconfirmed; presumptive or self-report

☐ Confirmed through assessment and clinical evaluation

**MENTAL HEALTH PROBLEM\***

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **How Confirmed\***

☐ Confirmed by prior evaluation or clinical records ☐ Unconfirmed; presumptive or self-report

☐ Confirmed through assessment and clinical evaluation

1. **Serious mental illness (SMI) and, if SMI, how confirmed*\**** *(major depression, schizophrenia, bipolar disorder, obsessive compulsive disorder (OCD), panic disorder, post-traumatic stress disorder (PTSD) and borderline personality disorder)*

☐ No, not SMI ☐Confirmed through assessment and clinical evaluation

☐ Unconfirmed; presumptive or self-report ☐Client doesn’t know

☐ Confirmed by prior evaluation ☐Client Refused

**DEVELOPMENTAL DISABILITY\***

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**CHRONIC HEALTH CONDITION\***

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**HIV / AIDS\***

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**PHYSICAL DISABILITY\***

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

1. **Documentation of the Disability and severity on File:** ☐No ☐Yes
2. **Currently receiving services/treatment for this condition?**

☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

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

☐Medicaid

☐Medicare

☐State Children’s Health Insurance

 ☐VA-Veteran’s Administration Medical Services

☐Employer-Provided Health Insurance

☐Health Insurance through Cobra

☐State Health Insurance for Adults

☐Private Insurance

**HUD Financial Assessment**

1. ***Area Median Income\**** ☐US 2012 ☐Big Island ☐Kauai ☐Maui ☐ Oahu
2. ***Income from Any Source\**** ☐No ☐Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected

**Please check all resources and enter the amount per MONTH\***

**Income Type Amount Income Type Amount**

☐ Earned Income (employment):

☐ Unemployment

☐ SSI:

☐ SSDI:

☐ VA Service Disability Compensation:

☐ VA Non-Service Disability Pension

☐ Private Disability Insurance:

☐ Worker’s Compensation:

☐ TANF

☐ Government Assistance:

☐ Social Security Retirement:

☐ Pension or Retirement Income (job):

☐ Child Support:

☐ Alimony or Other Spousal Support:

☐ Other:

 **TOTAL INCOME: $**

**Hawaii Specific Data Elements Assessment**

1. **If currently working, # of hours worked in the past week:**
2. ***Medical Information\**** *(Do you have any of the following medical problems)*

 ☐ Asthma ☐ Back/Spinal impairment ☐ Cancer

 ☐ Diabetes ☐ Emphysema ☐ Heart disease, high BP, Stroke history

 ☐ Kidney, renal disease ☐ Liver disease, cirrhosis, Hep C ☐ Other medical problems

 ☐ Client doesn’t know ☐ Client refused disclosure ☐ Data not collected

 ***Name of Medical Insurer***

1. ***Reason for Exit\*:***

☐ Unknown/disappeared/abandoned unit

☐ Successfully moved into housing

☐ Completed program

☐ Nonpayment of rent/program fees

☐ Noncompliance with program

☐ Criminal activity/destruction of property/violence

☐ Reached maximum time allowed by program

☐ Needs could not be met by program

☐ Disagreement with rules/persons

☐ Death

☐ Institutionalized: jail, hospital, SA treatment

☐ Moved out of state: mainland

☐ Moved out of state: Compact of Free Association

☐ Moved out of state: out of country

☐ Moved to different Island within State

☐ Other:

1. ***Forwarding Address*:**
2. ***Exit Destination: If ES, TH, or PH, which program?***

**HUD PATH Data**

1. ***Date of Status Determination*** **Client became enrolled in PATH**☐ No ☐Yes

**If no, reason not enrolled**☐ Client Found Ineligible ☐ Not enrolled for other reasons

1. ***Connection with SOAR***  ☐ No ☐ Yes ☐ Client doesn’t know ☐ Client Refused ☐ Data not collected