



# COHMIS

## HOPWA Exit Form

CLIENT NAME									
Last:									
First:									
Middle:						Suffix			
PROJECT NAME									
PROJECT EXIT DATE (MM/DD/YYYY)									
DESTINATION <span style="color: red;">(ALL CLIENTS)</span>									
<input type="checkbox"/> Place not meant for habitation (vehicle, anywhere outside)					<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA <b>PH</b>				
<input type="checkbox"/> Emergency Shelter, including hotel or motel paid for w/ emergency shelter voucher or RHY-funded Host Home					<input type="checkbox"/> Moved from one HOPWA funded project to HOPWA <b>TH</b>				
<input type="checkbox"/> Safe Haven					<input type="checkbox"/> Rental by client, with GPD TIP subsidy				
<input type="checkbox"/> Foster care home or foster care group home					<input type="checkbox"/> Rental by client, with VASH housing subsidy				
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility					<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons				
<input type="checkbox"/> Jail, prison or juvenile detention facility					<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy				
<input type="checkbox"/> Long-term care facility or nursing home					<input type="checkbox"/> Rental by client, with HCV voucher				
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility					<input type="checkbox"/> Rental by client in a public housing unit				
<input type="checkbox"/> Substance abuse treatment facility or detox center					<input type="checkbox"/> Rental by client, no ongoing housing subsidy				
<input type="checkbox"/> Residential project or halfway house with no homeless criteria					<input type="checkbox"/> Rental by client, with other ongoing housing subsidy				
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher					<input type="checkbox"/> Owned by client, no ongoing housing subsidy				
<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)					<input type="checkbox"/> Owned by client, with other ongoing housing subsidy				
<input type="checkbox"/> Host Home (non-crisis)					<input type="checkbox"/> No Exit Interview Completed				
<input type="checkbox"/> Staying or living with friends, <b>temporary tenure</b>					<input type="checkbox"/> Other				
<input type="checkbox"/> Staying or living with family, <b>temporary tenure</b>					<input type="checkbox"/> Deceased				
<input type="checkbox"/> Staying or living with friends, <b>permanent tenure</b>					<input type="checkbox"/> Client doesn't know				
<input type="checkbox"/> Staying or living with family, <b>permanent tenure</b>					<input type="checkbox"/> Client refused				
					<input type="checkbox"/> Data not collected				

DISABLING CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
PHYSICAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Physical Disability</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
DEVELOPMENTAL DISABILITY	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
CHRONIC HEALTH CONDITION	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Chronic Health Condition</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
HIV/AIDS	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
MENTAL HEALTH PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Mental Health Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
SUBSTANCE ABUSE PROBLEM	
<input type="checkbox"/> No <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Drug abuse <input type="checkbox"/> Both alcohol and drug abuse	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If YES for Substance Abuse Problem</b> <i>Expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?</i>	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR		
	<input type="checkbox"/> No <input type="checkbox"/> Yes*	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Domestic Violence Victim/Survivor		
When did this experience occur?	<input type="checkbox"/> Within the past three months <input type="checkbox"/> Three to six months ago (excluding six months exactly) <input type="checkbox"/> From six to twelve months ago (excluding one year exactly) <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
Are you currently fleeing?	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

CASH INCOME FOR INDIVIDUAL	
Income from Any Source?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
*If YES to Income from Any Source – Indicate all sources that apply	
Income Source (Check all that apply)	Monthly Amount
<input type="checkbox"/> Earned Income	
<input type="checkbox"/> Unemployment Insurance	
<input type="checkbox"/> Supplemental Security Income (SSI)	
<input type="checkbox"/> Social Security Disability Insurance (SSDI)	
<input type="checkbox"/> VA Service-Connected Disability Compensation	
<input type="checkbox"/> VA Non-Service Connected Disability Pension	
<input type="checkbox"/> Private Disability Insurance	
<input type="checkbox"/> Worker's Compensation	
<input type="checkbox"/> Temporary Assistance for Needy Families (TANF)	
<input type="checkbox"/> General Assistance (GA)	
<input type="checkbox"/> Retirement Income from Social Security	
<input type="checkbox"/> Pension or Retirement Income from a Former Job	
<input type="checkbox"/> Child Support	
<input type="checkbox"/> Alimony and Other Spousal Support	
<input type="checkbox"/> Other Cash Income (Specify: _____)	
<b>Total Monthly Amount</b>	

NON-CASH BENEFITS	
<b>Receiving Non-Cash Benefits?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Receiving Non-Cash Benefits – Indicate all sources that apply</b>	
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) <div style="float: right;"><input type="checkbox"/> TANF Transportation Services</div> <input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) <div style="float: right;"><input type="checkbox"/> Other TANF-Funded Services</div> <input type="checkbox"/> TANF Childcare Services <div style="float: right;"><input type="checkbox"/> Other Non-Cash Benefit (Specify source: _____)</div>	

HEALTH INSURANCE	
<b>Covered by Health Insurance?</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<b>*If YES to Covered by Health Insurance – Indicate all sources that apply AND Indicate Reason Not Covered by any Insurance Sources client does not have</b>	
Health Insurance Source	Reason Not Covered by Specific Insurance Source
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<input type="checkbox"/> Medicare	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<input type="checkbox"/> State Children's Health Insurance Program	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<input type="checkbox"/> Veteran's Administration (VA) Medical Services	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
<input type="checkbox"/> Employer-Provided Health Insurance	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>

Health Insurance Source (cont'd)	Reason Not Covered by Specific Insurance Source
<input type="checkbox"/> Health Insurance Obtained Through COBRA	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Private Pay Health Insurance	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> State Health Insurance for Adults	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Indian Health Services Program	<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<input type="checkbox"/> Other Health Insurance	(Specify Source: _____)

MEDICAL ASSISTANCE		
<b>Receiving Public HIV/AIDS Medical Assistance?</b>	<input type="checkbox"/> No* <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If NO for Receiving Public HIV/AIDS Medical Assistance</b>		
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>Receiving AIDS Drug Assistance Program (ADAP)?</b>	<input type="checkbox"/> No* <input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected
<b>*If NO for Receiving AIDS Drug Assistance Program</b>		
<input type="checkbox"/> Applied; decision pending <input type="checkbox"/> Applied; client not eligible <input type="checkbox"/> Client did not apply <input type="checkbox"/> Insurance type N/A for this client		<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected

T-CELL (CD4) AND VIRAL LOAD	
T-cell (CD4) Count Available?	<input type="checkbox"/> No <input type="checkbox"/> Yes* <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
*If <b>YES</b> to T-Cell (CD4) Count Available, T-Cell Count (# between 0 – 1500) =	
If a # is entered in the T-Cell (CD4) count, then how was information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other
Viral load information available?	<input type="checkbox"/> Not available <input type="checkbox"/> Available* <input type="checkbox"/> Undetectable <div style="float: right;"> <input type="checkbox"/> Client doesn't know  <input type="checkbox"/> Client refused  <input type="checkbox"/> Data not collected </div>
*If Viral Load Information is <b>AVAILABLE</b> , then Count (# between 0 – 999999) =	
If a # is entered in the Viral Load count, then how was information obtained?	<input type="checkbox"/> Medical report <input type="checkbox"/> Client report <input type="checkbox"/> Other

### Permanent Housing Projects Only (TBRA & Facility Based)

If Client is in a Permanent Housing Situation at time of Assessment:																			
HOUSING MOVE-IN DATE <i>(enter on Enrollment Screen for Head of Household)</i>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px; background-color: #cccccc;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px; background-color: #cccccc;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> <td style="width: 25px;"> </td> </tr> <tr> <td colspan="3">MONTH</td> <td colspan="3">DAY</td> <td colspan="3">YEAR</td> </tr> </table>										MONTH			DAY			YEAR		
MONTH			DAY			YEAR													
ZIP CODE:																			

CONTACT INFORMATION (Optional – entered on the Contacts tab)	
Phone number	
Email	

ADDRESS (Optional – entered on the Locations tab)			
Street			
City			
State		Zip Code	

Signature of applicant stating all information is true and correct

Date