Transitional Housing, Rapid Rehousing, and all other Projects
(complete this form for ALL Adults and Head of Household)

Client Name: ___________________________  HMIS Client ID#: ___________________________
(optional)
Exit Date: ______________________________

Reason for Leaving:

____ Completed Program
____ Criminal Activity/Violence
____ Death
____ Disagreement with Rules
____ Does not meet criteria for program
____ Goal Achieved
____ Goal Not Achieved
____ Left for housing opportunity before completing program
____ Needs could not be met
____ Non-compliance
____ Non payment of rent
____ Reached maximum time allowed
____ Unknown/ Disappeared
____ Other: ______________________________

Destination:

-----Homeless Situations -----
____ Emergency Shelter, incl. hotel/motel paid for w/ES voucher, or RHY funded Host Home shelter
____ Place not meant for human habitation
____ Save Haven

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

----- Temporary and Permanent Housing Situations -----
____ Moved from one HOPWA funded project to HOPWA PH
____ Moved from one HOPWA funded project to HOPWA TH
____ No exit interview completed
____ Owned by client, no ongoing housing subsidy
____ Owned by client, with ongoing housing subsidy
____ Permanent housing (other than RRH) for formerly homeless persons
____ Hotel/ Motel paid for without emergency shelter voucher
____ Host Home (non-crisis)
_____ Residential or halfway house with no homeless criteria
_____ Rental by client, with GPD TIP subsidy
_____ Rental by client, with VASH subsidy
_____ Rental by client with RRH or equivalent subsidy
_____ Rental by client with Housing Choice Voucher (HCV) (tenant or project based)
_____ Rental by client in a public housing unit
_____ Rental by client, no ongoing housing subsidy
_____ Rental by client, with other ongoing housing subsidy
_____ Staying or living with friends, temporary tenure (e.g. room, apartment or house)
_____ Staying or living with friends, permanent tenure
_____ Staying or living with family, temporary tenure (e.g. room, apartment or house)
_____ Staying or living with family, permanent tenure (e.g. room, apartment or house)
_____ Transitional Housing for Homeless persons (including homeless youth)

----- Other Destination -----
_____ Other: ______________________________________
_____ Client Doesn’t Know
_____ Client Refused
_____ Data Not Collected
_____ Deceased

Disabling Condition:
Do you have a DISABILITY of long duration?  ____Yes  ____No
For each disability, check “LCI” if it is expected to be of long, continued and indefinite duration, substantially impairs the individual’s ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:
____Yes  ____LCI Alcohol Use Disorder  ____Yes  ____LCI BOTH Alcohol & Drug Use Disorder  ____Yes  ____LCI Drug Use Disorder
____Yes  ____LCI Chronic Health Condition  ____Yes  ____LCI Developmental  _________ HIV/AIDS
____Yes  ____LCI Mental Health Disorder  ____Yes  ____LCI Physical Health

Medical Insurance:
Do you have Health Insurance/ Medical Assistance?  ____Yes  ____No
Source of Health Insurance/ Medical Assistance:
_____ Medicaid  ____Medicare
_____ State Children’s Health Insurance Program  ____Veteran’s Administration (VA) Medical Services
_____ Employer – Provided Health Insurance  ____Health Insurance obtained through COBRA
_____ State Health Insurance for Adults
_____ Indian Health Care  ____Other

Medicaid ID# ________________________________
Medicaid Insurance Company:  ____Total Care  ____Blue Cross Blue Shield  ____Fidelis
____ United Healthcare  ____Molina Healthcare

Client Location:  ____NY-505 (Onondaga/ Cayuga/ Oswego counties)
____NY-510 (Ithaca/ Tompkins County)
Income:
Do you have income? ____Yes ____No Total Monthly Income $________
Income Source and amount: (please write in the monthly amount below for each source)
- $____ Alimony/ Spousal Support
- $____ Earned Income
- $____ Pension/Retirement income from a job
- $____ Retirement Income from Social Security
- $____ Social Security Income (SSI)
- $____ Unemployment Insurance
- $____ VA Service-Connected Disability Compensation

Non-Cash Benefits:
Do you have Non-Cash Benefits? ____Yes ____No
Source of Non-Cash Benefits:
- _____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
- _____ Special supplemental Nutrition Program for (WIC) (HUD)
- _____ TANF Child Care Services (HUD)
- _____ TANF Transportation Services (HUD)
- _____ Other TANF-Funded Services (HUD); If “Other” Specify: _____________________________________