Please complete for each person served.

**Project Start Date:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ **Project Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

S**ervicePointClient ID** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First Name: MI**: **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Suffix**: \_­­\_\_\_\_\_\_\_\_

**Exit Date: *\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_***

**Reason for Leaving:**

 Left for housing opp. before completing program  Completed program
 Non-Payment of rent/occupancy charge  Non-Compliance with program
 Criminal activity/violence  Reached maximum time allowed
 Needs could not be met  Disagreement with rules/persons
 Death  Unknown/Disappeared

 Left for housing opportunity  Aged Out (youth only)

 Found Placement (youth only)  Reunification

 Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Destination or residence at program exit:**

**-HOMELESS SITUATION-**

 Place Not Meant for Habitation

 Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter

 Safe Haven

**-INSTITUTIONAL SITUATIONS-**

 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 Use Treatment Facility or Detox Center

**-TEMPORARY AND PERMANENT HOUSING SITUATIONS-**

 Residential Project or Halfway House with no Homeless Criteria

 Hotel or Motel Paid for without an Emergency Shelter Voucher

 Transitional Housing for Homeless Persons (includes homeless youth)

 Host Home (non-crisis)

 Staying or Living in a Friend’sRoom, Apartment or House

 Staying or Living in a Family Member’s Room, Apartment or House

 Rental by Client, with GPD TIP Subsidy

 Rental by Client, with VASH Subsidy

 Permanent Housing (other than RRH) for Formerly Homeless Persons

 Rental by Client, with RRH or Equivalent Subsidy

 Rental by Client, with HCV voucher (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

 Owned by Client, with Ongoing Housing Subsidy

 Owned by Client, No Ongoing Housing Subsidy

**-OTHER-**

 No Exit interview completed

 Other

 Deceased

 Client Doesn’t Know

 Client Refused

 Data Not Collected

**Income from any source?** Yes No Client Doesn’t Know Client Refused Data Not Collected

 **Monthly Income**

|  |  |  |
| --- | --- | --- |
| **Receiving Income** | **Source of Income** (*Check all that apply)* | **Income Amount** |
| Yes  No | Earned Income | $ |
| Yes  No | Unemployment Insurance  | $ |
| Yes  No | Supplemental Security Income (SSI)  | $ |
| Yes  No | Social Security Disability Income (SSDI)  | $ |
| Yes  No | VA Service Connected Disability Compensation  | $ |
| Yes  No | Private Disability Insurance | $ |
| Yes  No | Worker’s Compensation | $ |
| Yes  No |  Temporary Assistance for Needy Families (TANF) | $ |
| Yes  No | General Assistance  | $ |
| Yes  No | Retirement Income From Social Security | $ |
| Yes  No | VA Non-Service Connected Disability Pension | $ |
| Yes  No | Pension or Retirement Income from Another Job | $ |
| Yes  No | Child Support | $ |
| Yes  No | Alimony or Other Spousal Support  | $ |
| Yes  No | Other – Specify Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |
|  | **Total Monthly Income** | **$** |

**Non-Cash Benefit from any source?** Yes No Client Doesn’t Know Client Refused Data Not Collected

 **Non-Cash Benefits**

|  |  |  |
| --- | --- | --- |
| **Receiving Benefit** | **Source of Non-Cash Benefit** (*Check all that apply)* | **Benefit Amount** *(when applicable)* |
| Yes  No | Supplemental Nutrition Assistance Program (SNAP – Food Stamps)  | $ |
| Yes  No | Special Supplemental Nutrition Program for Women, Infants and Children (WIC) | $ |
| Yes  No | TANF Child Care services | $ |
| Yes  No | TANF Transportation services | $ |
| Yes  No | Other TANF-funded services | $ |
| Yes  No | Other Source – Specify Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

**Covered by Health Insurance?** Yes No Client Doesn’t Know Client Refused Data Not Collected

**Health Insurance**

|  |  |
| --- | --- |
| **Covered** | **Health Insurance Type** (*Check all that apply)* |
| Yes  No | MEDICAID |
| Yes  No | MEDICARE  |
| Yes  No | State Children’s Health Insurance Program  |
| Yes  No | Veteran’s Administration (VA) Medical Services  |
| Yes  No | Employer-Provided Health Insurance  |
| Yes  No | Health Insurance obtained through COBRA |
| Yes  No | Private Pay Health Insurance  |
| Yes  No | State Health Insurance for Adults |
| Yes  No | Indian Health Services Program  |
| Yes  No | Other – Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Health, Substance Use, and Disabilities**

|  |  |
| --- | --- |
| **Disability Type** | **If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently** |
| **Physical**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |
| **Developmental**Yes No Client Doesn’t Know Client Refused  DNC | **Not Required**YesNo Client Doesn’t Know Client Refused  DNC |
| **Chronic Health Condition**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |
| **HIV/AIDS**Yes No Client Doesn’t Know Client Refused  DNC | **Not Required**Yes No Client Doesn’t Know Client Refused  DNC |
| **Mental Health Disorder**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |
| **Alcohol Use Disorder**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |
| **Drug Use Disorder**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |
| **Both Alcohol and Drug Use Disorder**Yes No Client Doesn’t Know Client Refused  DNC | Yes No Client Doesn’t Know Client Refused  DNC |

**Current Living Situation**

**Start Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**End Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Information Date:** \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**Current Living Situation:**

**-HOMELESS SITUATIONS-**

 Place Not Meant for Habitation

 Emergency Shelter, including hotel/motel paid for w/ES voucher, or RHY-funded host home shelter

 Safe Haven

**-INSTITUTIONAL SITUATIONS-**

 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 Use Treatment Facility or Detox Center

**-OTHER-**

 Other

 Worker unable to determine

 Client Doesn’t Know

 Client Refused

 Data Not Collected

**Date of PATH Status Determination: \_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Became Enrolled in PATH:**  Yes  No

**If no, reason not enrolled:** Client was found ineligible for PATH

 Client was not enrolled for other reason(s)

 Unable to locate Client

**Connection with SOAR:** Yes No Client Doesn’t Know Client Refused Data Not Collected