Please complete one sheet for each person served, whether they are an individual or a family member

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

**Community Services Client ID** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

**Reason for Leaving:**

 Completed Program  Non-Payment of Rent
 Criminal activity/violence  Other, Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Death  Reached maximum time allowed
 Disagreement with Rules/Persons  Time Allowed Expired
 Left For Housing Opp. Before Completing the Program  Transfer to Another Program

 Needs Could Not Be Met  Unknown/Disappeared

 Non-Compliance With Program

**Destination or residence at program exit:**

**-HOMELESS SITUATIONS-**

 Place Not Meant for Habitation

 Emergency Shelter, including hotel or motel paid for with 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 Abuse Treatment Facility or Detox Center

**-TEMPORARY HOUSING SITUATIONS-**

 Transitional Housing for Homeless Persons (includes homeless youth)

 Residential Project or Halfway House with no Homeless Criteria

 Hotel or Motel Paid for without an Emergency Shelter Voucher

 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

 Moved from one HOPWA funded project to HOPWA TH

**-PERMANENT HOUSING SITUATIONS-**

 Staying or living with family

 Staying or living with friends

 Moved from one HOPWA funded project to HOPWA PH

 Rental by Client, No Ongoing Housing Subsidy

 Rental by Client, with Ongoing Housing Subsidy

 GPD TIP Housing Subsidy

 VASH Housing Subsidy

 RRH or Equivalent Subsidy

* + HCV voucher (tenant or project based) (Not Dedicated)
	+ Public Housing Unit
	+ Rental by Client With Other Ongoing Subsidy
	+ Housing Stability Voucher
	+ Family Unification Program Voucher (FUP)
	+ Foster Youth of Independence Initiative (FYI)
	+ Permanent Supportive Housing
	+ Other Permanent Housing Dedicated for Formerly Homeless Persons

 Owned by Client, with Ongoing Housing Subsidy

 Owned by Client, No Ongoing Housing Subsidy

**-OTHER-**

 No Exit Interview Completed

 Other, Specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Deceased

 Client Doesn’t Know

 Client Prefers Not to Answer

 Data Not Collected

***HUD CoC & ESG Exit (2026):***

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

 **Monthly Income**

|  |  |  |
| --- | --- | --- |
| **Receiving Income** | **Source of Income** (*Check all that apply)* | **Income Amount** |
| Yes  No | Alimony | $ |
| Yes  No | Alimony or Other Spousal Support  | $ |
| Yes  No | Annuities  | $ |
| Yes  No | Child Support  | $ |
| Yes  No | Contributions From Other People | $ |
| Yes  No | Dividends (Investments) | $ |
| Yes  No | Earned Income | $ |
| Yes  No | General Assistance  | $ |
| Yes  No | Interest | $ |
| Yes  No | Other | $ |
| Yes  No | Pension/Retirement | $ |
| Yes  No | Pension or Retirement Income from Another Job | $ |
| Yes  No | Private Disability Insurance | $ |
| Yes  No | Railroad Retirement | $ |
| Yes  No | Rental Income | $ |
| Yes  No | Retirement Disability | $ |
| Yes  No | Retirement Income From Social Security | $ |
| Yes  No | Self-Employment Wages | $ |
| Yes  No | SSDI | $ |
| Yes  No | SSI | $ |
| Yes  No | State Disability | $ |
| Yes  No | TANF | $ |
| Yes  No | Unemployment Insurance | $ |
| Yes  No | VA Non-Service Connected Disability Pension | $ |
| Yes  No | VA Service Connected Disability Compensation | $ |
| Yes  No | Worker’s Compensation  | $ |
| Yes  No | Other – Specify Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |
|  | **Total Monthly Income** | **$** |

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

**Non-Cash Benefit from any source?** Yes No Client Doesn’t Know Client Prefers Not to Answer 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 WIC | $ |
| Yes  No | TANF Child Care services | $ |
| Yes  No | TANF Transportation services | $ |
| Yes  No | Other TANF-funded services | $ |
| Yes  No | Other Source – Specify Source \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | $ |

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

**Covered by Health Insurance?** Yes No Client Doesn’t Know Client Prefers Not to Answer 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 Health Administration (VHA) 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

**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** |
| **Alcohol Use Disorder**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Both Alcohol and Drug Use Disorder**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Chronic Health Condition**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Developmental**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | **Not Required**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Drug Use Disorder**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **HIV/AIDS**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | **Not Required**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Mental Health Disorder**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Physical**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |
| **Physical/Medical**Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC | Yes No Client Doesn’t Know Client Prefers Not to Answer  DNC |

**Moving On Assistance Provided:**

**Date of Moving On Assistance:** **­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Moving On Assistance:**

 Subsidized Housing application assistance

 Financial assistance for Moving On (*security deposit, moving expenses*)

  Housing Referral/Placement

 Non-financial assistance for Moving On (*housing navigation, transition support*)

 Other (*Specify:*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)