

# HMIS EXIT Data Collection Form for Solano County VA SSVF Programs

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## General Instructions

This is the update form for VA SSVF programs in Solano County.

This form should be filled out for all household members and entered into HMIS accordingly.

Income and benefits collected by minor children in the household should be reported under the head of household.

No question should remain blank at the end of the assessment. The administrator of this intake must ask all questions of the client and mark the appropriate response.

Please note, current HMIS policies require that all data be entered into HMIS within three days of acquisition.

If you are confused about how to answer a question, please refer to the HMIS Data Dictionary which is contained in the resources folder for HMIS accessible through ServicePoint.

If the data dictionary does not answer your question, please reach out to [solanoHMIS@homebaseccc.org](mailto:solanoHMIS@homebaseccc.org) for assistance.

CLIENT NAME:

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DATE ADMINISTERED:

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## EXIT DESTINATION

### DESTINATION

Which of the following most closely matches where the client will be staying right after leaving this project?

<input type="checkbox"/>	Place not meant for habitation	<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA PH
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA TH
<input type="checkbox"/>	Safe Haven	<input type="checkbox"/>	Rental by client, with GPD TIP housing subsidy
<input type="checkbox"/>	Foster care 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 (tenant or project based)
<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, with ongoing housing subsidy
<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/>	Owned by client, no 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, temporary tenure	<input type="checkbox"/>	Other
<input type="checkbox"/>	Staying or living with family, temporary tenure	<input type="checkbox"/>	Deceased
<input type="checkbox"/>	Staying or living with family, permanent tenure	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Staying or living with friends, permanent tenure	<input type="checkbox"/>	Client refused

IF 'OTHER,' SPECIFY \_\_\_\_\_

## DISABILITY STATUS

Disability elements for HMIS data collections are based on client report. A client is not required to show proof of disability in order to respond "yes" to this question. Programs which require a disability for a client to be eligible for services may further investigate this element.

### PHYSICAL DISABILITY

Does the client currently have a physical disability?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES]** Is the physical disability expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### DEVELOPMENTAL DISABILITY

Does the client currently have a developmental disability?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES]** Is the developmental disability expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### CHRONIC HEALTH CONDITION

Does the client currently have a chronic health condition?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES]** Is the chronic health condition expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### HIV/AIDS

Does the client currently have HIV/AIDS?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES]** Is HIV/AIDS expected to substantially impair the client's ability to live independently?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

## DISABILITY STATUS (CONT.)

### MENTAL HEALTH PROBLEM

*Does the client currently have a mental health problem?*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES]** *Is the mental health problem expected to be of long-continued and indefinite duration and substantially impairs the client's ability to live independently?*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### SUBSTANCE ABUSE PROBLEM

*Does the client currently have a substance abuse problem?*

<input type="checkbox"/>	No	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Alcohol abuse	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Drug abuse		
<input type="checkbox"/>	Both alcohol and drug abuse		



**[IF YES for alcohol abuse, drug abuse, or both alcohol and drug abuse]** *Is the substance abuse problem expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

### DISABLING CONDITION

*A disabling condition is any of the above-indicated disabilities (physical disability, developmental disability, chronic health condition, HIV/AIDS, mental health problem, or substance abuse problem) or any other physical, mental, or emotional impairment (including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury) that is expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. **Does the client currently have a disabling condition?***

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

## INCOME AND BENEFITS

### INCOME AND SOURCES

Record regular, recurrent sources that are current (i.e. not terminated). Income received for a minor member of the household (e.g. SSI) should be recorded under the Head of Household's information (income from employment of a minor can be excluded from the household income). If the client has income, enter the monthly amount received. Answer 'No' for sources that have been terminated, even if they were received in the past.

Does the client have any income from any source?

<input type="checkbox"/> Yes	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> No	<input type="checkbox"/> Client refused



[IF YES] Answer Yes or No for each income source.

Source of income	Receiving income from source?	If yes, monthly amount from source (round to nearest dollar)
Earned income (i.e., employment income)	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Unemployment Insurance	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Supplemental Security Income (SSI)	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Social Security Disability Insurance (SSDI)	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
VA Service-Connected Disability Compensation	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
VA Non-Service-Connected Disability Pension	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Private disability insurance	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Worker's Compensation	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Temporary Assistance for Needy Families (TANF)	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
General Assistance (GA)	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Retirement Income from Social Security	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Pension or retirement income from a former job	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Child support	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Alimony or other spousal support	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
Other source If yes, specify source: _____	Yes <input type="checkbox"/>	
	No <input type="checkbox"/>	\$ . 0 0
<b>Total monthly income from all sources</b>		\$ . 0 0

## INCOME AND BENEFITS (CONT.)

### PERCENTAGE OF AMI

<input type="checkbox"/>	Less than 30%
<input type="checkbox"/>	30% – 50%
<input type="checkbox"/>	Greater than 50%

### Does the client have a connection with SOAR?

<input type="checkbox"/>	Yes
<input type="checkbox"/>	No
<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Client refused

**Does the client have any non-cash benefits from any source?** *Only record regular, recurrent sources that are current as of today (not terminated). If a non-cash benefit is only received by a minor member of the household, record under the Head of Household's information.*

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES] Answer 'Yes' or 'No' for each non-cash benefit source.** *Answer 'No' for sources that have been terminated, even if they were received in the past.*

Yes	No	Source of income
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP)
<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
<input type="checkbox"/>	<input type="checkbox"/>	TANF Child Care services
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services
<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

### Is the client currently covered by health insurance?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



**[IF YES] Answer 'Yes' or 'No' for each health insurance source.** *Answer 'No' for sources that have been terminated, even if they were received in the past.*

Yes	No	Source
<input type="checkbox"/>	<input type="checkbox"/>	Medicaid
<input type="checkbox"/>	<input type="checkbox"/>	Medicare
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services
<input type="checkbox"/>	<input type="checkbox"/>	Employer-Provided Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	Health insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Other: _____

## EMPLOYMENT

Is the client employed?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



If YES, what is the type of employment?

<input type="checkbox"/>	Full-time	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Part-time	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Seasonal/sporadic (including day labor)		

If NO, why is the client not employed?

<input type="checkbox"/>	Looking for work	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Unable to work	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Not looking for work		

## DOMESTIC VIOLENCE EXPERIENCE

Is client a domestic violence victim or survivor?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused



If YES, when did the experience occur?

<input type="checkbox"/>	Within the past three months	<input type="checkbox"/>	One year ago or more
<input type="checkbox"/>	Three to six months ago (excluding six months exactly)	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Six months to one year ago (excluding one year exactly)	<input type="checkbox"/>	Client refused

If YES, is the client currently fleeing?

<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	No	<input type="checkbox"/>	Client refused

If YES, caller ZIP Code: \_\_\_\_\_



## CLIENT'S RESIDENCE OR LAST PERMANENT ADDRESS

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

County \_\_\_\_\_

Phone number \_\_\_\_\_ Email address \_\_\_\_\_

What is the data quality of the client's residence or last permanent address?

<input type="checkbox"/>	Full address reported	<input type="checkbox"/>	Client doesn't know
<input type="checkbox"/>	Incomplete or estimated address reported	<input type="checkbox"/>	Client refused

## EMERGENCY CONTACT

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone number \_\_\_\_\_ Email address \_\_\_\_\_

## LANDLORD CONTACT

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone number \_\_\_\_\_ Email address \_\_\_\_\_

## EMPLOYER CONTACT

Name \_\_\_\_\_

Address \_\_\_\_\_ Apt/Unit \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

Phone number \_\_\_\_\_ Email address \_\_\_\_\_