# CLARITY HMIS: KC- EMPLOYMENT
# PROJECT EXIT FORM

**Use block letters for text and bubble in the appropriate circles.**
**Please complete a separate form for each household member.**

**CLIENT NAME OR IDENTIFIER:** _____

**PROGRAM EXIT DATE** *[All Individual/Clients]*

| | | - | | | - | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Month | | | Day | | | Year | | | |

**DESTINATION** *[All Clients]*

| | | | |
|---|---|---|---|
| ○ | Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport, or anywhere outside) | ○ | Moved from one HOPWA funded project to HOPWA TH |
| ○ | Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or Host Home shelter | ○ | Staying or living with family, permanent tenure |
| ○ | Safe Haven | ○ | Staying or living with friends, permanent tenure |
| ○ | Foster care home or foster care group home | ○ | Moved from one HOPWA funded project to HOPWA PH |
| ○ | Hospital or other residential non--psychiatric medical facility | ○ | Rental by client, no ongoing housing subsidy |
| ○ | Jail, prison or juvenile detention facility | ○ | **Rental by client, with ongoing housing subsidy** |
| ○ | Long-term care facility or nursing home | ○ | Owned by client, with ongoing housing subsidy |
| ○ | Psychiatric hospital or other psychiatric facility | ○ | Owned by client, no on-going housing subsidy |
| ○ | Substance abuse treatment facility or detox center | ○ | No exit interview completed |
| ○ | Transitional housing for homeless persons (including homeless youth) | ○ | Other |
| ○ | Residential project or halfway house with no homeless criteria | ○ | Deceased |
| ○ | Hotel or motel paid for without emergency shelter voucher | ○ | Client doesn't know |
| ○ | Host Home (non-crisis) | ○ | Client prefers not to answer |
| ○ | Staying or living with family, temporary tenure (e.g., room, apartment, or house) | ○ | Data not collected |
| ○ | Staying or living with friends, temporary tenure (e.g., room, apartment, or house) | | |
| **IF "RENTAL BY CLIENT, WITH ONGOING HOUSING SUBSIDY" – SPECIFY:** | | | |
| ○ | GDP TIP housing subsidy | ○ | Emergency Housing Voucher |

| | | | |
|---|---|---|---|
| ○ | VASH Housing subsidy | ○ | Family Unification Program Voucher (FUP) |
| ○ | RRH or equivalent subsidy | ○ | Foster Youth to Independence Initiative (FYI) |
| ○ | HCV voucher (tenant or project based) (not dedicated) | ○ | Permanent Supportive Housing |
| ○ | Public Housing Unit | ○ | Other permanent housing dedicated for formerly homeless persons |
| ○ | Rental by client, with other ongoing housing subsidy | | |

| ***If Destination is "Place not meant for habitation"** | | | | |
|---|---|---|---|---|
| **Is household's destination living situation in a vehicle?** | ○ | No | ○ | Client doesn't know |
| | ○ | Yes | ○ | Client prefers not to answer |
| | | | ○ | Data not collected |

| If "Yes", please select Vehicle type | | | |
|---|---|---|---|
| ○ | Van | ○ | Client Doesn't Know |
| ○ | Automobile/Car | ○ | Client prefers not to answer |
| ○ | Camper/RV | ○ | Data Not Collected |

**If Destination is permanent housing**

**CITY OF PERMANENT HOUSING LOCATION**

| | | | |
|---|---|---|---|
| ○ | Unincorporated King County (includes any community not otherwise listed) | ○ | Medina |
| ○ | Algona | ○ | Mercer Island |
| ○ | Auburn | ○ | Milton |
| ○ | Beaux Arts | ○ | Newcastle |
| ○ | Bellevue | ○ | Normandy Park |
| ○ | Black Diamond | ○ | North Bend |
| ○ | Bothell | ○ | Pacific |
| ○ | Burien | ○ | Redmond |
| ○ | Carnation | ○ | Renton |
| ○ | Clyde Hill | ○ | Sammamish |
| ○ | Covington | ○ | Sea Tac |
| ○ | Des Moines | ○ | Seattle |
| ○ | Duvall | ○ | Shoreline |
| ○ | Enumclaw | ○ | Skykomish |
| ○ | Federal Way | ○ | Snoqualmie |
| ○ | Hunts Point | ○ | Tukwila |
| ○ | Issaquah | ○ | Woodinville |
| ○ | Kenmore | ○ | Yarrow Point |
| ○ | Kent | ○ | Washington State (outside of King County) |
| ○ | Kirkland | ○ | Outside of Washington State |
| ○ | Lake Forest Park | ○ | Client Doesn't Know |

| | | | |
|---|---|---|---|
| ○ | Maple Valley | ○ | Client prefers not to answer |
| | | ○ | Data Not Collected |

**HOUSEHOLD IS PERMANENTLY HOUSED WITH SUFFICIENT EMPLOYMENT INCOME TO MAINTAIN THAT HOUSING**

| | | | |
|---|---|---|---|
| ○ | No | ○ | Client doesn't know |
| ○ | Yes | ○ | Client prefers not to answer |
| | | ○ | Data not collected |

**IF "YES" TO PERMANENTLY HOUSED WITH SUFFICIENT EMPLOYMENT INCOME** *[Head of Household and Adults]*

| | |
|---|---|
| **Employment Start Date** | ____/____/_____ |
| **Hourly Wage** | $_____ |
| **Place of Employment** | _____ |

**Industry Sector**

| | | | |
|---|---|---|---|
| ○ | Natural Resources and Mining | ○ | Professional and Business Services |
| ○ | Construction | ○ | Education and Health Services |
| ○ | Manufacturing | ○ | Leisure and Hospitality |
| ○ | Trade, Transportation, and Utilities | ○ | Client doesn't know |
| ○ | Information | ○ | Client prefers not to answer |
| ○ | Financial Activities | ○ | Data not collected |

**DISABLING CONDITION** *[All Individuals/Clients]*

*If individual/client is in need of resources, contact the following as appropriate:*

- *For aging or disability support, call the Community Living Connections Line at: 206-962-8467/1-844-348-5464(Toll Free),*
- *For crisis services: Crisis Connections at: 1-866-427-4747,*
- *For mental health or substance use services: King County Behavioral Health Recovery Client Services Line: 1-800-790-8049,*
- *For confidential peer support: Washington Warm Line 1-877-500-WARM(9276).*

**DOES THE INDIVIDUAL/CLIENT HAVE:**

**A PHYSICAL DISABILITY** and/or a **PHYSICAL HEALTH CONDITION** *[All Individuals/Clients]*

| | | | |
|---|---|---|---|
| ○ | No | ○ | Client doesn't know |
| ○ | Yes | ○ | Client prefers not to answer |
| | | ○ | Data not collected |

| IF "YES" TO PHYSICAL DISABILITY – SPECIFY | | | | |
|---|---|---|---|---|
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | o | No | o | Client doesn't know |
| | o | Yes | o | Client prefers not to answer |
| | | | o | Data not collected |

**A DEVELOPMENTAL DISABILITY** *[All Individuals/Clients]*

| | | | |
|---|---|---|---|
| o | No | o | Client doesn't know |
| o | Yes | o | Client prefers not to answer |
| | | o | Data not collected |

**A CHRONIC HEALTH CONDITION** *[All Individuals/Clients]*

| | | | |
|---|---|---|---|
| o | No | o | Client doesn't know |
| o | Yes | o | Client prefers not to answer |
| | | o | Data not collected |

| IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY | | | | |
|---|---|---|---|---|
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | o | No | o | Client doesn't know |
| | o | Yes | o | Client prefers not to answer |
| | | | o | Data not collected |

**A MENTAL HEALTH CONDITION** *[All Individuals/Clients]*

| | | | |
|---|---|---|---|
| o | No | o | Client doesn't know |
| o | Yes | o | Client prefers not to answer |
| | | o | Data not collected |

| IF "YES" TO MENTAL HEALTH PROBLEMS – SPECIFY | | | | |
|---|---|---|---|---|
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently | o | No | o | Client doesn't know |
| | o | Yes | o | Client prefers not to answer |
| | | | o | Data not collected |

**A SUBSTANCE ABUSE ISSUE** *[ All Individuals/Clients]*

| | | | |
|---|---|---|---|
| o | No | o | Both alcohol & drug use disorder |
| o | Alcohol use disorder | o | Client doesn't know |
| | | o | Client prefers not to answer |
| o | Drug use disorder | o | Data not collected |

| IF "ALCOHOL ABUSE" "DRUG USE DISORDER" OR "BOTH ALCOHOL AND DRUG USE DISORDER"– SPECIFY | | | | |
|---|---|---|---|---|
| Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? | o | No | o | Client doesn't know |
| | o | Yes | o | Client prefers not to answer |

**INCOME FROM ANY SOURCE** *[Head of Household and Adults]*

| | | | |
|---|---|---|---|
| ○ | No | ○ | Client doesn't know |
| ○ | Yes | ○ | Client prefers not to answer |
| | | ○ | Data not collected |

**IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY**

| | **Income Source** | **Amount** | | **Income Source** | **Amount** |
|---|---|---|---|---|---|
| ○ | Earned Income | | ○ | Temporary Assistance for Needy Families (TANF) | |
| ○ | Unemployment Insurance | | ○ | General Assistance (GA) | |
| ○ | Supplemental Security Income (SSI) | | ○ | Retirement Income from Social Security | |
| ○ | Social Security Disability Insurance (SSDI) | | ○ | Pension or Retirement Income from a Former Job | |
| ○ | VA Service-Connected Disability Compensation | | ○ | Child Support | |
| ○ | VA Non-Service-Connected Disability Pension | | ○ | Alimony and Other Spousal Support | |
| ○ | Private Disability Insurance | | ○ | Other Income source | |
| ○ | Worker's Compensation | | | | |
| **Total Monthly Income for Individual:** | | | | | |

**RECEIVING NON -CASH BENEFITS** [*Head of Household and Adults]*

| | | | |
|---|---|---|---|
| ○ | No | ○ | Client doesn't know |
| ○ | Yes | ○ | Client prefers not to answer |
| | | ○ | Data not collected |

**IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY**

| | | | |
|---|---|---|---|
| ○ | Supplemental Nutrition Assistance Program (SNAP) | ○ | TANF Childcare Services |
| ○ | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) | ○ | TANF Transportation Services |
| ○ | Other Non-Cash Benefit | ○ | Other TANF-funded services |

**COVERED BY HEALTH INSURANCE** *[All Individuals/Clients]*

| | | | |
|---|---|---|---|
| ○ | No | ○ | Client doesn't know |
| ○ | Yes | ○ | Client prefers not to answer |
| | | ○ | Data not collected |

| IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS | | | |
|---|---|---|---|
| ○ | MEDICAID | ○ | Employer Provided Health Insurance |
| ○ | MEDICARE | ○ | Insurance Obtained through COBRA |
| ○ | State Children's Health Insurance (SCHIP) | ○ | Private Pay Health Insurance |
| ○ | Veterans Health Administration (VHA) | ○ | State Health Insurance for Adults |
| ○ | Other (specify) | ○ | Indian Health Services Program |

***If applicable:***

**Signature of applicant stating all information is true and correct** **Date**