**CLARITY HMIS: KC-HHS-PATH 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 DayYear

DESTINATION *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
| ○ | Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subwaystation/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 on­going 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 |

**CONNECTION WITH SOAR** ​*[Heads of Households and Adults*]

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

# **PATH STATUS** [If not at intake]

|  |  |  |
| --- | --- | --- |
| Date of Status Determination |  | \_\_\_\_/\_\_\_/\_\_\_\_\_\_\_ |
| Client Became Enrolled in PATH | ○ | No |
| ○ | Yes |
| **IF “NO” TO ENROLLED IN PATH** | | |
| Reason Not Enrolled | ○ | Client was found ineligible for PATH |
| ○ | Client was not enrolled for other reason(s) |
| ○ | Unable to locate client |

**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? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

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

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

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
| ○ | Data not collected |
| **IF “YES” TO CHRONIC HEALTH CONDITION – SPECIFY** | | | | | |
| Expected to be of long-continued and indefinite duration? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| ○ | No | | | ○ | Client doesn’t know |
| ○ | Yes | | | ○ | Client prefers not to answer |
| ○ | Data not collected |
| **IF “YES” TO MENTAL HEALTH PROBLEMS – SPECIFY** | | | | | |
| Expected to be of long-continued and indefinite duration? | | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

**A SUBSTANCE ABUSE ISSUE** ​*[Head of Household and Adults]*

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **IF “ALCOHOL USE DISORDER” “DRUG USE DISORDER” OR “BOTH ALCOHOL AND DRUG USE DISORDER”– SPECIFY** | | | | |
| Expected to be of long-continued and indefinite duration? | ○ | No | ○ | Client doesn’t know |
| ○ | Yes | ○ | Client prefers not to answer |
| ○ | Data not collected |

**MONTHLY INCOME AND SOURCES** ​*[Head of Households 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 | |  | ○ | TANF (Temporary Assist for Needy Families) | | | |  | |
| ○ | Unemployment Insurance | |  | ○ | General Assistance (GA) | | | |  | |
| ○ | Supplemental Security Income (SSI) | |  | ○ | Retirement Income from Social Security | | | |  | |
| ○ | Social Security Disability Insurance (SSDI) | |  | ○ | Pension or retirement income from 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 | |  | ○ | Other income source | | |  | | | |
| **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 NON­CASH 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 (specify): | ○ | 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**