



A Tradition of Stewardship
A Commitment to Service

Napa County Continuum of Care

Standard HMIS Child Client Exit

Program Name: _____ Case Worker/Intake Person: _____ Program Exit Date: _____

CLIENT EXIT

Separate client exits should be completed for each client who is **under** the age of 18 unless they are the Head of Household. **Separate client exits must be completed for adults as well, but please be sure to use the Standard HMIS Adult Client Exit form.**

1) Client Name	First	Last																				
2) Project Exit Date	<table border="1" style="margin: auto; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 10px; height: 20px; text-align: center;">/</td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> <tr> <td colspan="2" style="text-align: center;">Month</td> <td></td> <td colspan="2" style="text-align: center;">Day</td> <td></td> <td colspan="4" style="text-align: center;">Year</td> </tr> </table>			/			/					Month			Day			Year				
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Month			Day			Year																

The Project Exit Date will serve as the information date for all data elements collected on this form; all data must be accurate as of this date, regardless of the date collected.

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

Client Name _____

Head of Household Name (if not Self) _____

Homeless Situations

- Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport/or anywhere outside)
- Emergency Shelter, including hotel or motel paid for with emergency shelter voucher, or 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 (including homeless youth)
- Residential project or halfway house with no homeless criteria
- Hotel or motel paid for without emergency shelter voucher
- Host Home (non-crisis)
- Staying or living with family, temporary tenure (e.g., room, apartment, or house)
- Staying or living with friends, temporary tenure (e.g., room, apartment, or house)

Permanent Housing Situations

- Staying or living with family, permanent tenure
- Staying or living with friends, permanent tenure
- Rental by client, no ongoing housing subsidy
- Rental by client, with ongoing housing subsidy**
- Owned by client, with ongoing housing subsidy
- Owned by client, no ongoing housing subsidy

Other

(Other than Deceased, there are very limited situations applicable to these options. Please verify there is not a more appropriate option prior to using them.)

- No exit interview completed
- Other (specify): _____
- Deceased
- Client doesn't know
- Client prefers not to answer
- Data Not Collected

Client Name _____

Head of Household Name (if not Self) _____

Rental Subsidy Type: If “Rental by client, with ongoing housing subsidy” is selected, please select the type of housing subsidy in use.	<input type="checkbox"/> GPD TIP housing subsidy <input type="checkbox"/> VASH housing subsidy <input type="checkbox"/> RRH or equivalent subsidy <input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated) <input type="checkbox"/> Public housing unit <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Emergency Housing Voucher (EHV) <input type="checkbox"/> Family Unification Program Voucher (FUP) <input type="checkbox"/> Foster Youth to Independence Initiative (FYI) <input type="checkbox"/> Permanent Supportive Housing <input type="checkbox"/> Other permanent housing dedicated for formerly homeless persons	
HOUSING ASSESSMENT AT EXIT: [Homelessness Prevention programs only]		
What is the client’s housing status?	<input type="checkbox"/> Able to maintain the housing they had at project entry <input type="checkbox"/> Moved to new housing unit <input type="checkbox"/> Moved in with family/friends on a temporary basis <input type="checkbox"/> Moved in with family/friends on a permanent basis <input type="checkbox"/> Moved to a transitional or temporary housing facility or program <input type="checkbox"/> Client became homeless – moving to a shelter or other place unfit for human habitation <input type="checkbox"/> Jail/prison <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected	
If the client was “Able to Maintain Housing at Project Entry,” please answer the following question about subsidy information:	<input type="checkbox"/> Without a subsidy <input type="checkbox"/> With the subsidy they had at project entry <input type="checkbox"/> With an ongoing subsidy acquired since project entry <input type="checkbox"/> Only with financial assistance other than a subsidy	
If the client “Moved to a New Housing Unit,” please answer the following question about subsidy information:	<input type="checkbox"/> With ongoing subsidy <input type="checkbox"/> Without an ongoing subsidy	
DISABLING CONDITIONS: A Disabling Condition is a health condition that interferes with getting and/or keeping stable housing.		
1) Does the client have a Physical Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected	
If Yes, is it 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"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected	
2) Does the client have a Developmental Disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected	
3) Does the client have a Chronic Health Condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn’t know <input type="checkbox"/> Client prefers not to answer	

Client Name _____

Head of Household Name (if not Self) _____

<p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>4) Does the client have HIV – AIDS?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>5) Does the client have a Mental Health Disorder?</p> <p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>
<p>6) Does the client have any Substance Use Disorder?</p> <p>If Yes, is it expected to be of long, continued and indefinite duration and substantially impair the client's ability to live independently?</p>	<p><input type="checkbox"/> No <input type="checkbox"/> Alcohol use disorder <input type="checkbox"/> Drug use disorder <input type="checkbox"/> Both Alcohol & Drug Abuse Use Disorders <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p>

HEALTH INSURANCE

<p>Currently covered by health insurance? <i>Is the client currently covered by health insurance?</i></p> <p>If Yes, type(s) of insurance(s): <i>If the client is currently covered by multiple health insurances please select all that apply.</i></p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data Not Collected</p> <p><input type="checkbox"/> Medicaid (same as Medi-Cal) <input type="checkbox"/> Medicare <input type="checkbox"/> State Children's Health Insurance (CHIP) Program <input type="checkbox"/> Veteran's Health Administration (VHA) <input type="checkbox"/> Employer-Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained Through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program</p>
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Client Name _____

Head of Household Name (if not Self) _____

Other Health Insurance

If Other Specify: _____

Client Name _____

Head of Household Name (if not Self) _____