

HMIS Project Discharge Form *Emergency Shelter & Street Outreach (Including PATH)*

Step 1: Basic Client Information

Please complete the following basic client information and note that all fields with an * are required fields. This information is used to close an open enrollment by performing the exit workflow. The response "Data Not Collected" means the question was not asked of the client and will report as missing on reports.

Basic Client Information:*

First Name:* _____ Last Name:* _____
 Middle Name: _____ Suffix: _____
 Birthdate:* _____ Social Security Number:* _____

Step 2: Project Exit

Complete the project exit information and please note all fields with an * are required fields. Complete additional forms for each household member to be exited.

Exit Date:* _____

(ONLY REQUIRED FOR PATH PARTICIPANTS):

Date of PATH Status Determined:* _____
 Client Became Enrolled in PATH:* Yes No *(Client formally consents to participate in PATH program services)*
 Reason Not Enrolled in PATH:*
 Client was found ineligible for PATH
 Client not enrolled for other reasons
 Connection with SOAR:*
 Yes No
 Client Doesn't Know Client Refused

Destination:*

- Emergency Shelter, including hotel or motel paid for with shelter voucher
- Transitional housing for homeless persons (including homeless youth)
- Permanent Supportive Housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)
- Psychiatric Hospital or Other Psychiatric Facility
- Substance Abuse Treatment or Detox Center
- Hospital or other residential non-psychiatric medical facility
- Jail, Prison, Juvenile Detention Facility
- Long-term care facility or nursing home
- Moved from one HOPWA funded project to HOPWA PH
- Moved from one HOPWA funded project to HOPWA TH
- Rental by client, no ongoing housing subsidy
- 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)
- Hotel or Motel paid for without emergency shelter voucher
- Foster Care Home or Foster Care Group Home

Destination:* Continued

- Place not meant for habitation (vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- Hotel or Motel paid for without emergency shelter voucher
- Foster Care Home or Foster Care Group Home
- Place not meant for habitation (e.g., vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
- Other
- Safe Haven
- Rental by client, VASH Subsidy
- Rental by client, with GPD TIP housing subsidy
- Residential project or halfway house with no homeless criteria
- No exit interview completed
- Rental by client, other (non-VASH) ongoing housing subsidy
- Owned by client, with ongoing housing subsidy
- Staying or living with family, permanent tenure
- Staying or living with friends, permanent tenure
- Deceased
- Client Don't Know
- Client Refused
- Data Not Collected

Exit Reason:*

- | | |
|---------------------------------------------------------------------------------------|--------------------------------------------------------------|
| <input type="checkbox"/> Left for a housing opportunity before completing the program | <input type="checkbox"/> Needs could not be met by program |
| <input type="checkbox"/> Completed program | <input type="checkbox"/> Disagreement with rules/persons |
| <input type="checkbox"/> Non-payment of rent/occupancy charge | <input type="checkbox"/> Death |
| <input type="checkbox"/> Non-compliance with Program | <input type="checkbox"/> Other*
(Other Exit Reason _____) |
| <input type="checkbox"/> Criminal activity/destruction of property/violence | <input type="checkbox"/> Unknown/Disappeared |
| <input type="checkbox"/> Reached maximum time allowed by program | End Case Assignment: <input type="checkbox"/> |

Covered by Health Insurance:*

If Yes, Type:*

- | | | |
|----------------------------------------------|--------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> Private - COBRA | <input type="checkbox"/> Military Insurance |
| <input type="checkbox"/> No | <input type="checkbox"/> Private – Employer | <input type="checkbox"/> Other Public |
| <input type="checkbox"/> Client Doesn't Know | <input type="checkbox"/> Private – Individual | <input type="checkbox"/> State Funded (HIP or HIP 2.0) |
| <input type="checkbox"/> Client Refused | <input type="checkbox"/> Medicare | <input type="checkbox"/> Indian Health Service (Native American) |
| <input type="checkbox"/> Data Not Collected | <input type="checkbox"/> Medicaid | <input type="checkbox"/> Other _____ |
| | <input type="checkbox"/> State Children's Health Insurance Program (S-CHIP; not Medicaid or HIP) | |

Status:*

- | | | | |
|--------------------------------------------|-------------------------------------------------------------|----------------------------------------------|--|
| <input type="checkbox"/> Active | <input type="checkbox"/> No | | |
| <input type="checkbox"/> Start Date: _____ | <input type="checkbox"/> Applied; decision pending | <input type="checkbox"/> Client Doesn't Know | |
| <input type="checkbox"/> End Date: _____ | <input type="checkbox"/> Applied; client not eligible | <input type="checkbox"/> Client Refused | |
| | <input type="checkbox"/> Client did not apply | <input type="checkbox"/> Data Not Collected | |
| | <input type="checkbox"/> Insurance type N/A for this client | | |

<u>Barriers:*</u>	<u>Barrier Present?</u>	<u>Receiving Services/Treatment?</u>	<u>Condition Indefinite?</u>	<u>Documentation on File?</u>
Alcohol Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Developmental Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIV/AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Mental Health	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chronic Health Condition	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused <input type="checkbox"/> Data Not Collected	<input type="checkbox"/> Yes <input type="checkbox"/> No

HMIS Barriers Assessment:*

If client reports "Alcohol Abuse, Drug Abuse and/or Mental Health" as present barriers, complete the following:

How confirmed:

- Unconfirmed; presumptive or self-report
- Confirmed through assessment and clinical evaluation
- Confirmed by prior evaluation or clinical records

Financial Assessment:* **Cash Income:*** Yes No

- Earned Income \$ _____
- Private Disability Insurance \$ _____
- Unemployment Insurance \$ _____
- Worker's Compensation \$ _____
- Pension From Former Job (VA Included) \$ _____
- Supplemental Security Income \$ _____
- Social Security Disability Income \$ _____
- Retirement (Social Security) \$ _____
- Alimony \$ _____
- VA Service-Connected Disability \$ _____
- VA Non Service-Connected Disability \$ _____
- TANF \$ _____
- Child Support \$ _____
- Other Income \$ _____

Non Cash Benefits:* Yes No

- Food Stamps/Money for Food on Benefits Card \$ _____
- Special Supplemental Nutrition Program (WIC)
- TANF Child Care Services
- TANF Transportation Services
- Other TANF Funded Services
- Section 8, Public Housing, Other Rental Asst. (PSH) \$ _____
- Temporary Rental Assistance (RRH) \$ _____
- Other Source

(ONLY REQUIRED FOR PATH PARTICIPANTS)

Date of Contact:* _____

Contact with: _____

Enrollment:* _____

Contact Service:*

- Assessments: PATH Screening/Assessment
- Case Management: PATH – Case Management
- Health/Medical: PATH – Referral Primary Health Services
- Mental Health/Counseling: PATH – Referral Community Mental Health
- Prevention/Outreach: PATH – Outreach
- Substance Abuse: PATH – Referral Substance Abuse Treatment

Current Location:*

- Place Not Meant for Habitation
- Service Setting, Non-Residential
- Service Setting, Residential