



MSCCoC_MIS ESG Project Exit

Community Alliance for the Homeless | Management Information Systems | Tanyce McCray-Davis | MIS Director/System Admin II
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FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

Date of Data Collection

		/			/			
Month			Day			Year		

Client ID

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NAME (first, middle, last name, suffix (e.g., Jr, Sr, III)) [All clients]

First Name:																				
Middle Name:																				
Last Name:																				
Suffix:																				
Alias:																				

Social Security Number: [All clients]

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Date of Birth: (e.g., 10/23/1978) [All clients]

		/			/				
Month			Day			Year			

DESTINATION

<input type="checkbox"/>	Deceased (HUD)	<input type="checkbox"/>	Owned by client, with ongoing housing subsidy (HUD)	<input type="checkbox"/>	Residential project or halfway house with no homeless criteria (HUD)
<input type="checkbox"/>	Emergency shelter, including hotel or motel paid for with emergency shelter voucher (HUD)	<input type="checkbox"/>	Permanent housing for formerly homeless persons (HUD)	<input type="checkbox"/>	Safe Haven (HUD) Staying or living with family, permanent tenure (HUD)
<input type="checkbox"/>	Foster care home or foster care group home (HUD)	<input type="checkbox"/>	Place not meant for habitation (HUD)	<input type="checkbox"/>	Staying or living with family, temporary tenure (e.g., room, apartment or house)(HUD)
<input type="checkbox"/>	Hospital or other residential non-psychiatric medical facility(HUD)	<input type="checkbox"/>	Psychiatric hospital or other psychiatric facility (HUD)	<input type="checkbox"/>	Staying or living with friends, permanent tenure (HUD)
<input type="checkbox"/>	Hotel or motel paid for without emergency shelter voucher (HUD)	<input type="checkbox"/>	Rental by client, no ongoing housing subsidy (HUD)	<input type="checkbox"/>	Staying or living with friends, temporary tenure (e.g., room apartment or house) (HUD)
<input type="checkbox"/>	Jail, prison or juvenile detention facility (HUD) Longterm care facility or nursing home (HUD)	<input type="checkbox"/>	Rental by client, with VASH subsidy (HUD)	<input type="checkbox"/>	Substance abuse treatment facility or detox center (HUD)
<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWAPH (HUD)	<input type="checkbox"/>	Rental by client, with GPD TIP subsidy (HUD)	<input type="checkbox"/>	Transitional housing for homeless persons (including homeless youth) (HUD)
<input type="checkbox"/>	Moved from one HOPWA funded project to HOPWA TH (HUD)	<input type="checkbox"/>	Rental by client, with other ongoing housing subsidy (HUD)	<input type="checkbox"/>	Other (HUD)
<input type="checkbox"/>	No exit interview completed (HUD)	<input type="checkbox"/>	Client refused (HUD)	<input type="checkbox"/>	Staying in a family member's apartment/house/room
<input type="checkbox"/>	Client doesn't know (HUD)	<input type="checkbox"/>	Data not collected (HUD)	<input type="checkbox"/>	Permanent: Moved in with family or friends
<input type="checkbox"/>	If "Other", Specify				

INCOME & SOURCES *PROOF NEEDED*

What is the Household total monthly income?

\$ _____

Have you received income from any source? No Yes

If yes for "Income from any source:

Indicate all sources and dollar amounts for the source that apply:

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Earned income (i.e. employment income)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Worker's Compensation	\$
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Security Income (SSI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Social Security Disability Income (SSDI)	\$	<input type="checkbox"/>	<input type="checkbox"/>	General Assistance (GA)	\$
<input type="checkbox"/>	<input type="checkbox"/>	VA Service Connected Disability Compensation	\$	<input type="checkbox"/>	<input type="checkbox"/>	VA Non Service Connected Disability Pension	\$
<input type="checkbox"/>	<input type="checkbox"/>	Retirement Income from Social Security	\$	<input type="checkbox"/>	<input type="checkbox"/>	Responses Pension or retirement income from a former job	\$
<input type="checkbox"/>	<input type="checkbox"/>	Private disability insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Child support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Unemployment Insurance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Alimony and other spousal support	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source (specify	\$				

NON-CASH BENEFITS *PROOF NEEDED*

Have you received non-cash benefits from any source?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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If yes for non-cash benefits from any source and dollar amounts for the source that apply:

No	Yes	Source of Benefit	Amount	No	Yes	Source of Benefit	Amount
<input type="checkbox"/>	<input type="checkbox"/>	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	\$
<input type="checkbox"/>	<input type="checkbox"/>	SANF Child Care services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary Assistance for Needy Families (TANF)	\$
<input type="checkbox"/>	<input type="checkbox"/>	TANF transportation services (or use local name)	\$	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF unded Services (or use local name)	\$
<input type="checkbox"/>	<input type="checkbox"/>	Section 8, public housing, or other ongoing rental assistance	\$	<input type="checkbox"/>	<input type="checkbox"/>	Temporary rental assistance	\$
<input type="checkbox"/>	<input type="checkbox"/>	Other Source	\$	If yes to "Other" Source, please specify			

DISABILITY INFORMATION *PROOF NEEDED*

Does client have a disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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ALCOHOL ABUSE

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/		/			
				Month		Day		Year						

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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CHRONIC HEALTH CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
						Month			Day			Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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DEVELOPMENTAL DISABILITY

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
						Month			Day			Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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HIV/AIDS

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
						Month			Day			Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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MENTAL HEALTH CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:				/		/			
						Month			Day			Year	

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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PHYSICAL CONDITION

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/		/					
								Month		Day		Year				

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Is there Documentation of the disability and severity on file?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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Currently receiving services/treatment for this disability?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused	<input type="checkbox"/>	Data not collected
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INSURANCE INFORMATION *PROOF NEEDED*

COVERED BY HEALTH INSURANCE?

<input type="checkbox"/>	No	<input type="checkbox"/>	Yes	Date Information Collected:					/		/				
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HEALTH INSURANCE PROVIDERS

NO	YES		NO	YES	
<input type="checkbox"/>	<input type="checkbox"/>	MEDICAID	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance obtained through COBRA
<input type="checkbox"/>	<input type="checkbox"/>	MEDICARE	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance
<input type="checkbox"/>	<input type="checkbox"/>	State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults (or use local name)
<input type="checkbox"/>	<input type="checkbox"/>	Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program
<input type="checkbox"/>	<input type="checkbox"/>	Employer - Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other

OUTREACH

Date of Engagement:

		/			/				
Month		Day		Year					

Date of Contact

		/			/				
Month		Day		Year					

Start Date

		/			/				
Month		Day		Year					

End Date:

		/			/				
Month		Day		Year					

Housing Move In Date

		/			/				
Month		Day		Year					

ASSESSMENT DISPOSITION

<input type="checkbox"/>	Referred to Emergency Shelter/Safe Haven	<input type="checkbox"/>	Referred to Homeless Diversion Program
<input type="checkbox"/>	Referred to Transitional Housing	<input type="checkbox"/>	Unable to refer/accept within continuum; ineligible for continuum projects
<input type="checkbox"/>	Referred to Rapid Rehousing	<input type="checkbox"/>	Unable to refer/accept within continuum; continuum services unavailable
<input type="checkbox"/>	Referred to Permanent Supportive House	<input type="checkbox"/>	Referred to other continuum project; (non-continuum).
<input type="checkbox"/>	Referred to Homelessness Prevention	<input type="checkbox"/>	Applicant declined referral/acceptance
<input type="checkbox"/>	Referred to Street Outreach	<input type="checkbox"/>	Applicant terminated assessment prior to completion
<input type="checkbox"/>	Referred to Other Continuum Project Type	<input type="checkbox"/>	Other/Specify

IF OTHER ASSESSMENT, PLEASE SPECIFY _____

HOUSING ASSESSMENT AT EXIT

<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 on-going subsidy acquired since project entry.	<input type="checkbox"/>	Client became homeless-moving to a shelter or other place unfit for human habitation
<input type="checkbox"/>	Client went to jail/prison	<input type="checkbox"/>	Client died
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Data not collected		

IF ABLE TO MAINTAIN HOUSING AT ENTRY, SUBSIDY INFORMATION

<input type="checkbox"/>	Without subsidy	<input type="checkbox"/>	With subsidy they had at project entry	<input type="checkbox"/>	With an ongoing subsidy acquired since project entry
<input type="checkbox"/>	Only financial assistance other than subsidy	<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Data Not Collected				

IF MOVED TO NEW HOUSING UNIT, SUBSIDY INFORMATION

<input type="checkbox"/>	With ongoing subsidy	<input type="checkbox"/>	Without ongoing subsidy
<input type="checkbox"/>	Client doesn't know	<input type="checkbox"/>	Client refused
<input type="checkbox"/>	Data Not Collected		