MSCCOC CLIENT EXIT FORM

CoC/ES

FOR TEXT FIELDS, USE BLOCK LETTERS. OTHERWISE, MARK APPROPRIATE BOXES WITH AN "X". Complete a separate form for each member of the household.

PROJECT ENTRY DATE (e.g., 08/24/2014) *[All clients]*

		/			/				

Month Date Year

MIS Client ID

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]*

			-			-			

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

		/			/			

Month Date Year

CLIENT LOCATION: TN-501

Date of Exit:

		/			/				

Month Day Year

Reason for Leaving

☐	Completed program	☐	Needs could not be met	☐	Reached maximum time allo
☐	Death	☐	Non-compliance with program	☐	Shelter Night Stay Complete
☐	Criminal activity / violence	☐	Non-payment of rent	☐	Unknown/Disappeared
☐	Disagreement with rules/p	☐	Left for housing opp. before con program	☐	Other (specify

Destination

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

INCOME & SOURCES *PROOF NEEDED*

Income from Any Source

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

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	
☐	☐	Earned income (i.e. employn income)	$	☐	☐	Worker's Compensation	$
☐	☐	Supplemental Security Incor (SSI)	$	☐	☐	Temporary Assistance for Needy Families (TANF)	$
☐	☐	Social Security Disability Inc (SSDI)	$	☐	☐	General Assistance (GA)	$
☐	☐	VA Service-Connected Disab Compensation	$	☐	☐	Retirement Income from Social Security	$
☐	☐	VA Non-Service-Connected Disability Pension	$	☐	☐	Responses Pension or retirement income from a former job	$
☐	☐	A Non-Service-Connected Disability Pension	$	☐	☐	Child support	$
☐	☐	Private disability insurance	$	☐	☐	Alimony and other spousal support	$
☐	☐	Unemployment Insurance	$				
☐	☐	"Other Source"	$	Specify Source:			

NON-CASH BENEFITS

Have you received non-cash benefits from any source in the last 30 days?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

If yes for "non-cash benefits from any source and dollar amounts for the source that apply

No	Yes	Dollar Amount (if any)	Source of Benefit
☐	☐	$	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)
☐	☐	$	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐	☐	$	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)
☐	☐	$	TANF Child Care services *(or use local name)*

☐	☐	$	TANF transportation services *(or use local name)*
☐	☐	$	Other TANF-Funded Services *(or use local name)*
☐	☐		Section 8, public housing, or other ongoing rental assistance
☐	☐	$	Temporary rental assistance
☐	☐	$	Other source:
☐	☐	$	If Yes for "Other" Source, please specify:

DISABILITY INFORMATION *[All Clients]* *PROOF NEEDED*

Does client have a disability?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

TYPE OF DISABILITY

Alcohol Abuse ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Chronic Health Condition ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Developmental Disability ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

HIV/AIDS ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Mental Health Condition ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Physical Condition ☐No ☐Yes

Date Information was Collected:

Month Day Year

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

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Is there Documentation of the disability and severity on file?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

Currently receiving services/treatment for this disability?

☐ No ☐Yes ☐ Client Doesn't Know ☐Client Refused ☐ Data not Collected

HEALTH INSURANCE *[All Clients]* *PROOF NEEDED*

Covered by Health Insurance

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused
		☐	Data not collected

Indicate all sources that apply

NO	YES	
☐	☐	MEDICAID
☐	☐	MEDICARE
☐	☐	State Children's Health Insurance Program (or use local name)
☐	☐	Veteran's Administration (VA) Medical Services
☐	☐	Employer – Provided Health Insurance
☐	☐	Health Insurance obtained through COBRA
☐	☐	Private Pay Health Insurance
☐	☐	State Health Insurance for Adults (or use local name)
☐	☐	Indian Health Services Program
☐	☐	Other
☐	☐	If yes to Other) Specify source:

OUTREACH

Date of Contact

		/			/				

Month Date Year

Location

Start Date

		/			/				

Month Date Year

End Date

		/			/				
Month			Date				Year		

Residential Move-in Date

		/			/				
Month			Date				Year		