MSCCOC MIS CLIENT EXIT FORM

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

PROJECT EXIT 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																				

Housing Status *[All clients]* ***PROOF NEEDED***

☐	Category 1 - Homeless	☐	At-risk of homelessness
☐	Category 2 – At imminent risk of losing housing	☐	Stably housed
☐	Category 3 – Homeless under other federal statutes (**NOT USED BY HOMELESS PROJECTS**)	☐	Client doesn't know
☐	Category 4 – Fleeing domestic violence	☐	Client refused

Reason for Leaving *[All clients]*

☐	Completed program	☐	Non-compliance with program
☐	Criminal activity / violence	☐	Non-payment of rent
☐	Death	☐	Other
☐	Disagreement with rules/persons	☐	Reached maximum time allowed
☐	Left for housing opp. before completing program	☐	Time allowed expired
☐	Needs could not be met	☐	Unknown/Disappeared

Destination *[All Clients]* ***PROOF NEEDED***

☐	Deceased	☐	Rental by client, no ongoing housing subsidy
☐	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	☐	Rental by client, with VASH housing subsidy
☐	Foster care home or foster care group home	☐	Rental by client, with GPD TIP housing subsidy
☐	Hospital or other residential non-psychiatric medical facility	☐	Rental by client, with other ongoing housing subsidy
☐	Hotel or motel paid for without emergency shelter voucher	☐	Safe Haven
☐	Jail, prison, or juvenile detention facility	☐	Staying or living with family, permanent tenure
☐	Long-term care facility or nursing home	☐	Staying or living with family, temporary tenure (e.g., room, apartment, or house)
☐	Moved from one HOPWA funded project to HOPWA PH	☐	Staying or living with friends, permanent tenure
☐	Moved from one HOPWA funded project to HOPWA TH	☐	Staying or living with friends, temporary tenure (e.g., room, apartment, or house)
☐	Owned by client, no ongoing housing subsidy	☐	Substance abuse treatment facility or detox center
☐	Owned by client, with other ongoing housing subsidy	☐	Other (Describe) _____
☐	Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab)	☐	Client doesn't know
☐	Place not meant for human habitation (e.g., a vehicle, abandoned building, park, or anywhere outside)	☐	Client refused
☐	Psychiatric hospital or other psychiatric facility		

Income & Sources *[Head of Household & Adults over 18]* ***PROOF NEEDED***

Have you received income from any source in the last 30 days?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] *Answer Yes or No for each income source. If the response for a source is 'Yes', enter the monthly amount received based on current income. If unsure of the exact monthly amount, enter client's best estimate.*

No	Yes	Source of Income	Amount	No	Yes	Source of Income	Amount
☐	☐	Alimony or Spousal Support	$	☐	☐	Sup. Sec. Income (SSI)	$
☐	☐	Child Support	$	☐	☐	TANF	$
☐	☐	Earned Income (Employed)	$	☐	☐	Unemployment Insurance	$
☐	☐	General Assistance	$	☐	☐	VA Non-Service Disability Pension	$
☐	☐	Pension or Income for Retiring	$	☐	☐	VA Service Disability Compensation	$
☐	☐	Private Disability Insurance	$	☐	☐	Workers Compensation	$
☐	☐	Retirement Income from Soc. Sec.	$	☐	☐	Other: _____	$
☐	☐	Soc. Sec. Disability Income (SSDI)	$	☐	☐	**Total Monthly Income:**	$

Non-Cash Benefits *[Head of Household & Adults over 18]* ***PROOF NEEDED***

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

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] *Answer 'Yes' or 'No' for each non-cash benefit source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)*

No	Yes	Source of Income
☐	☐	Section 8, Public Housing, or other rental assistance
☐	☐	Special Supplemental Nutrition Assistance Program (SNAP)
☐	☐	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)*
☐	☐	Temporary rental assistance. If yes, specify source:_____
☐	☐	Other source:_____

Health Insurance *[All Clients]* ***PROOF NEEDED***

Covered by health Insurance

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

[IF YES] *Answer 'Yes' or 'No' for each health insurance source. (Answer 'No' for benefits that have been terminated, even if they were received in the past.)*

No	Yes	Source of Income
☐	☐	Employer-Provided Health Insurance
☐	☐	Health insurance obtained through COBRA
☐	☐	Medicaid **(TN-CARE)**
☐	☐	Medicare
☐	☐	Private Pay Health Insurance
☐	☐	State Children's Health Insurance Program **(Cover Kids)**
☐	☐	State Health Insurance for Adults
☐	☐	Veteran's Administration (VA) Medical Services

Disability Information *[All Clients]* ***PROOF NEEDED***

Does the Client have a disability?

☐	No	☐	Client doesn't know
☐	Yes	☐	Client refused

Disability Information *[All Clients]* ***PROOF NEEDED***

Type of Disability			Is the disability long term & impairs the client ability to live independently?		Is there documentation on the severity of the disability?		Is the client receiving services/treatment for the disability?	
No	**Yes**		**No**	**Yes**	**No**	**Yes**	**No**	**Yes**
☐	☐	**Alcohol Abuse**	☐	☐	☐	☐	☐	☐
☐	☐	**Chronic Health Condition**	☐	☐	☐	☐	☐	☐
☐	☐	**Developmental Disability**	☐	☐	☐	☐	☐	☐
☐	☐	**Drug Abuse**	☐	☐	☐	☐	☐	☐
☐	☐	**HIV/AIDS**	☐	☐	☐	☐	☐	☐
☐	☐	**Mental Health Condition**	☐	☐	☐	☐	☐	☐
☐	☐	**Physical Disability**	☐	☐	☐	☐	☐	☐