Complete a separate form for each Adult. [All Clients = Adults & Children]

**Please carefully READ the instructions before answering these questions.**

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Last Name**: |  | | | | **Middle:** | |  | **First:** | | |  | |
| **Social Security #**: | | | |  | | | **Date of Birth**: | |  | | | |
| **Project Name**: | | |  | | | | **Project Exit Date**: | | | | |  |
| **Case Manager**: | |  | | | | **Head of Household**: | | | |  | | |

**HOUSING STATUS AT EXIT** *[ALL Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | Category 1 – Homeless (Will sleep tonight in an Emergency Shelter or Place Not Meant For Habitation) | | |  | Stably Housed | | |
|  | Category 2 - At Imminent Risk of Losing Housing |  | At-risk of homelessness | | |  | Data Not Collected |
|  | Fleeing domestic violence |  | Client Doesn’t Know | | |  | Client Refused |

**DESTINATION** *[ALL Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | Deceased |  | Rental by client, with VASH subsidy |
|  | Emergency shelter, including hotel or motel paid for with emergency shelter voucher |  | Rental by client, with GPD TIP subsidy |
|  | Foster care home or group home |  | Rental by client, with other ongoing  Housing subsidy |
|  | Hospital or other residential non-  psychiatric medical facility |  | Residential project or halfway house  With no homeless criteria |
|  | Hotel or motel paid for without emergency shelter voucher |  | Staying or living *with family,* permanent tenure (e.g. room, apartment or house) |
|  | Jail, prison or juvenile detention facility |  | Staying or living *with family,* temporary tenure (e.g. room, apartment or house) |
|  | Long-term care facility or nursing home |  | Staying or living *with friends,* permanent tenure (e.g. room, apartment or house) |
|  | Owned by client, NO ongoing housing subsidy |  | Staying or living *with friends,* temporary tenure (e.g. room, apartment or house) |
|  | Owned by client, WITH ongoing housing subsidy |  | Substance abuse treatment facility or detox center |
|  | Permanent housing for formerly homeless persons (such as: CoC project) |  | Transitional housing for homeless persons (including homeless youth) |
|  | Place not meant for habitation (e.g. vehicle, abandoned building, bus/train/subway station, airport or anywhere outside) |  | Other (**Specify “Other**”)   |  | | --- | |  | |
|  | Psychiatric hospital or other psychiatric facility |  | No exit interview completed |
|  | Rental by client, NO ongoing housing subsidy |  | Client doesn’t know |
|  | Client refused |

**Reason for LEaVING** [*ALL Clients]*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Left for a housing opportunity before completing program |  | Criminal activity/destruction of property / violence |  | Death |
|  | Completed Program |  | Reached maximum time allowed by program |  | Client doesn’t know |
|  | Non-payment of rent / occupancy charge |  | Needs could not be met by program |  | Unknown / disappeared |
|  | Non-compliance with program |  | Disagreement with rules/person |  | Other |

**RESIDENTIAL MOVE-IN DATE (ESG and RRH Programs *ONLY*)**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| HAS THE CLIENT MOVED INTO PERMANENT HOUSING? | | | |  | | No | | | |  | | Yes | | |
| If “YES”, Date Of Residential Move-In: |  |  | / | |  | |  | / |  | |  | |  |  |

**PHYSICAL DISABILITY** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO PHYSICAL DISABILITY – SPECIFY** | | | | | | | |
| Receiving services for physical disability | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the physical disability expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**DEVELOPMENTAL DISABILITY** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO DEVELOPMENTAL DISABILITY – SPECIFY** | | | | | | | |
| Receiving services for developmental disability | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the developmental disability expected to substantially impair ability to live independently? | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**CHRONIC HEALTH CONDITION** *[All Clients]*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | | |
|  | Yes |  | Client refused | | | | | |
| **IF “YES” TO CHRONIC HEALTH CONDITION – SPECIFY** | | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes | |

**HIV-AIDS** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | |
|  | Yes |  | Client refused | | | | |
| **IF “YES” TO HIV-AIDS – SPECIFY** | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the condition expected to substantially impair ability to live independently? | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**MENTAL HEALTH PROBLEMS** *[All Clients]*

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Client doesn’t know | | | | | |
|  | Yes |  | Client refused | | | | | |
| **IF “YES” TO MENTAL HEALTH PROBLEMS – SPECIFY** | | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know | |
|  | Yes |  | Client refused | |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | | Client doesn’t know |
|  | Yes |  | | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | | Yes |

**SUBSTANCE ABUSE PROBLEMS** *[All Clients]*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | No |  | Both alcohol and drug abuse | | | | |
|  | Alcohol abuse |  | Client doesn’t know | | | | |
|  | Drug abuse |  | Client refused | | | | |
| **IF “YES” TO ALCOHOL ABUSE, DRUG ABUSE OR BOTH – SPECIFY** | | | | | | | |
| Currently receiving services/treatment for this condition | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| Is the condition expected to be of long-continued and indefinite duration and substantially impairs ability to live independently. | | | |  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |
| **Documentation of the disability and severity on file** | | | |  | No |  | Yes |

**DISABLING CONDITION** *[All Clients]*

|  |  |  |  |
| --- | --- | --- | --- |
|  | No |  | Client doesn’t know |
|  | Yes |  | Client refused |

**COVERED BY HEALTH INSURANCE** *[All Clients]*

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Yes | |  | No | |  | Client Doesn’t Know | |  | Client Refused |
| **IF “YES” TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS** | | | | | | | | | | |
|  | | MEDICAID (aka Medi-Cal) | | |  | | Obtained through COBRA | | | |
|  | | MEDICARE | | |  | | Private Pay Health Insurance | | | |
|  | | VA Medical | | |  | | Indian Health Services Program | | | |
|  | | Employer Provided | | |  | | Other: (Specify) |  | | |

**EMPLOYMENT**

*[All Clients,* ***For Age 16 & Over****]*

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IS CLIENT EMPLOYED** | | | | | | | | | | | |
|  | Yes | |  | No | | |  | Client Doesn’t Know |  | Client Refused | |
| **If “Yes” To Employed** | | | | | | | | | | | |
|  | | Permanent | | |  | Client Doesn’t Know | | | | | |
|  | | Temporary | | |  | Client Refused | | | | | |
|  | | Seasonal | | | Hours Worked Last Week: | | | | | |  |
| **If “No” To Employed – Are You Seeking Employment?** | | | | | | | | | | | |
|  | Yes | |  | No | | |  | Client Doesn’t Know |  | Client Refused | |

**EDUCATION**

*[All Clients,* ***For Age 5 & over****]*

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **IS CLIENT CURRENTLY ENROLLED IN SCHOOL** | | | | | | | | | | | | | | | |
|  | | Yes |  | No | | | |  | Client Doesn’t Know | | | |  | | Client Refused |
| **Highest Educational Level Completed:** | | | | | | | | | | | | | | | |
|  | No School Completed | | | | |  | 10th Grade | | | | |  | | Postsecondary School | |
|  | Nursery School to 4th Grade | | | | |  | 11th Grade | | | | |  | | Client Doesn’t Know | |
|  | 5th or 6th Grade | | | | |  | 12th Grade, No Diploma | | | | |  | | Client Refused | |
|  | 7th or 8th Grade | | | | |  | High School Diploma | | | | |  | |  | |
|  | 9th Grade | | | | |  | GED | | | | |  | |  | |
| **Name of School Enrolled:** | | | | |  | | | | | | | | | | |
| **Type of School:** | | | | |  | Public | | | |  | Parochial or Other Private School | | | | |
| **Is Child Connected To The Homeless Liaison?** | | | | | | | | | | | | | | | |
|  | | Yes |  | No | | | |  | Client Doesn’t Know | | | |  | | Client Refused |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **If NOT Enrolled:** | | | | |
| Date Of Their Last Enrollment: | | |  | |
| **Barrier To Enrolling Child In School:**  **:** | | | | |
|  | None |  | | Lack Of An Available Preschool Program | |
|  | Residency Requirements |  | | Immunization Requirements | |
|  | Availability Of School Records |  | | Physical Examination Records | |
|  | Birth Certificate |  | | Other | |
|  | Legal Guardianship Required |  | | Don’t Know | |
|  | Transportation |  | | Refused | |