

# HMIS Exit Form for Emergency Shelter projects

Effective 10/01/2025

Exit Date

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ServicePoint  
(HoH) ID:

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Project Name

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Head of Household Name

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first

middle

last

suffix

SSN Last four digits

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If Partial Household Exit (if the whole household is existing, skip to Destination)

Name of Client(s) Exiting	Client ID

Reason for Leaving

Completed Program <input type="checkbox"/>	Completed Step <input type="checkbox"/>	Criminal activity/violence <input type="checkbox"/>	Disagreement with rules/persons <input type="checkbox"/>	Left for housing opp. Before completing program <input type="checkbox"/>
Needs could not be met <input type="checkbox"/>	Non-compliance with program <input type="checkbox"/>	Non-payment of rent <input type="checkbox"/>	Other <input type="checkbox"/>	Reached maximum time allowed <input type="checkbox"/>
Unknown/Disappeared <input type="checkbox"/>				

Destination (Where will you stay tonight?)

Homeless Situations	Institutional Situations	Temporary Housing Situations	Permanent Housing Situation	Other
<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)  <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter  <input type="checkbox"/> Safe Haven	<input type="checkbox"/> Foster care home or foster care group home  <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility  <input type="checkbox"/> Jail, prison, or juvenile detention facility  <input type="checkbox"/> Long-term care facility or nursing home  <input type="checkbox"/> Psychiatric hospital or other psychiatric facility  <input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH	<input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with ongoing housing subsidy (if yes, choose type): <ul style="list-style-type: none"> <li><input type="checkbox"/> GPD TIP housing subsidy</li> <li><input type="checkbox"/> VASH housing subsidy</li> <li><input type="checkbox"/> RRH or equivalent subsidy</li> <li><input type="checkbox"/> HCV voucher (tenant or project based) (not dedicated)</li> <li><input type="checkbox"/> Public housing unit</li> <li><input type="checkbox"/> Rental by client, with other ongoing housing subsidy</li> <li><input type="checkbox"/> Housing Stability Voucher</li> </ul>	<input type="checkbox"/> No exit interview completed <input type="checkbox"/> Other <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Data not collected

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			<ul style="list-style-type: none"> <li>○ Family Unification Program Voucher (FUP)</li> <li>○ Foster Youth to Independence Initiative (FYI)</li> <li>○ Permanent Supportive Housing</li> <li>○ Other permanent housing dedicated for formerly homeless persons</li> </ul> <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	
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## Is anyone in the Household receiving Health Insurance?

☐ Yes

☐ No

Source	Recipient(s)	Source	Recipient(s)
<input type="checkbox"/> Medicaid		<input type="checkbox"/> Employer-provided Health Insurance	
<input type="checkbox"/> Medicare		<input type="checkbox"/> Health insurance obtained through COBRA	
<input type="checkbox"/> State Children's Health Insurance Program (SCHIP)		<input type="checkbox"/> Private Pay Health Insurance	
<input type="checkbox"/> Veteran's Health Administration (VHA)		<input type="checkbox"/> State Health Insurance for Adults	
<input type="checkbox"/> Indian Health Services Program		<input type="checkbox"/> Other: _____	

## Disability Information:

Name	Condition	Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Expected to substantially impair ability to live independently:
	<input type="checkbox"/> Physical <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental <input type="checkbox"/> Alcohol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Physical <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental <input type="checkbox"/> Alcohol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Physical <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental <input type="checkbox"/> Alcohol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Physical <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental <input type="checkbox"/> Alcohol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No
	<input type="checkbox"/> Physical <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Mental Health <input type="checkbox"/> Developmental <input type="checkbox"/> Alcohol <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Yes  <input type="checkbox"/> No	<input type="checkbox"/> Yes  <input type="checkbox"/> No

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**Any Adult in the Household currently receiving income?**

☐ **Yes** (identify below)

☐ **No**

Source	Amount	Recipient(s)	Source	Amount	Recipient(s)
<input type="checkbox"/> Alimony or other spousal support	\$		<input type="checkbox"/> Social Security Income (SSI)	\$	
<input type="checkbox"/> Cash assistance/TANF	\$		<input type="checkbox"/> Social Sec Disability Income (SSDI)	\$	
<input type="checkbox"/> Child Support	\$		<input type="checkbox"/> Unemployment	\$	
<input type="checkbox"/> Earned Income	\$		<input type="checkbox"/> VA Service Connected Disability	\$	
<input type="checkbox"/> Pension from a former job	\$		<input type="checkbox"/> Veteran's Pension	\$	
<input type="checkbox"/> Retirement from Social Security	\$		<input type="checkbox"/> Worker's Compensation	\$	
<input type="checkbox"/> Private Disability Insurance	\$		<input type="checkbox"/> General Assistance	\$	
<input type="checkbox"/> Other Sources? Source _____	\$		<input type="checkbox"/> Other Sources? Source _____	\$	
<b>Total Monthly Income (record separately for each adult)</b>	\$		<b>Total Monthly Income (record separately for each adult)</b>	\$	

**Any adult in the Household currently receiving Non-Cash Benefits?**

☐ **Yes**

☐ **No**

Source	Recipient(s)	Source	Recipient(s)
<input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP/CalFresh)		<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)			
<input type="checkbox"/> TANF transportation services			
<input type="checkbox"/> Other TANF-funded services			

## Client Contact Information

<b>Client Phone Number</b>	
<b>Alt. Client Phone Number</b>	
<b>Email address/other electronic communication (e.g. social media)</b>	
<b>On a regular day, where is it easiest to find you and what time of day is easiest to do so? (collect multiple locations)</b>	