HMIS Exit Form for TBRA projects

Effective 10/01/2025

Exit Date

		/			/		

ServicePoint (HoH) ID:

Project Name

Head of Household Name

first middle last suffix

SSN Last four digits

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

Destination (Where will you stay tonight?)				
Homeless Situations	**Institutional Situations**	**Temporary Housing Situations**	**Permanent Housing Situation**	**Other**
☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, Host Home shelter ☐ Safe Haven	☐ Foster care home or foster care group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison, or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	☐ Transitional housing for homeless persons (including homeless youth) ☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Host Home (non-crisis) ☐ Staying or living with family, temporary tenure (e.g., room, apartment, or house) ☐ Staying or living with friends, temporary tenure (e.g., room, apartment, or house) ☐ Moved from one HOPWA funded project to HOPWA TH	☐ Staying or living with family, permanent tenure ☐ Staying or living with friends, permanent tenure ☐ Moved from one HOPWA funded project to HOPWA PH ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with ongoing housing subsidy (if yes, choose type): ○ GPD TIP housing subsidy ○ VASH housing subsidy ○ RRH or equivalent subsidy ○ HCV voucher (tenant or project based) (not dedicated) ○ Public housing unit ○ Rental by client, with other ongoing housing subsidy ○ Housing Stability Voucher	☐ No exit interview completed ☐ Other ☐ Deceased ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

			○ Family Unification Program Voucher (FUP) ○ Foster Youth to Independence Initiative (FYI) ○ Permanent Supportive Housing ○ Other permanent housing dedicated for formerly homeless persons ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy	

Any Adult in the Household currently receiving income? ☐ **Yes** *(identify below)* ☐ **No**

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

Any adult in the Household currently receiving Non-Cash Benefits? ☐ **Yes** ☐ **No**

Source	Recipient(s)	Source	Recipient(s)
☐ Supplemental Nutrition Assistance Program (SNAP/CalFresh)		☐ Other: _____	
☐ Special Supplemental, Nutrition Program for Women, Infants, and Children (WIC)			
☐ TANF transportation services			
☐ Other TANF-funded services			

Is anyone in the Household receiving Health Insurance? ☐ **Yes** ☐ **No**

Source	Recipient(s)	Source	Recipient(s)
☐ Medicaid		☐ Employer-provided Health Insurance	
☐ Medicare		☐ Health insurance obtained through COBRA	
☐ State Children's Health Insurance Program (SCHIP)		☐ Private Pay Health Insurance	
☐ Veteran's Health Administration (VHA)		☐ State Health Insurance for Adults	
☐ Indian Health Services Program		☐ 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:
	☐ Physical ☐ Drug Abuse ☐ Mental Health ☐ Developmental ☐ Alcohol ☐ HIV/AIDS ☐ Chronic Health Condition	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Physical ☐ Drug Abuse ☐ Mental Health ☐ Developmental ☐ Alcohol ☐ HIV/AIDS ☐ Chronic Health Condition	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Physical ☐ Drug Abuse ☐ Mental Health ☐ Developmental ☐ Alcohol ☐ HIV/AIDS ☐ Chronic Health Condition	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Physical ☐ Drug Abuse ☐ Mental Health ☐ Developmental ☐ Alcohol ☐ HIV/AIDS ☐ Chronic Health Condition	☐ Yes ☐ No	☐ Yes ☐ No
	☐ Physical ☐ Drug Abuse ☐ Mental Health ☐ Developmental ☐ Alcohol ☐ HIV/AIDS ☐ Chronic Health Condition	☐ Yes ☐ No	☐ Yes ☐ No