Agency Name: _____

CLARITY HMIS: VA-SSVF PROGRAM EXIT FORM

Use block letters for text and bubble in the appropriate circles.
Please complete a separate form for each household member.

PROGRAM EXIT DATE *[All Clients]*

Month Day Year

CURRENT NAME [*All Clients*]																N/A
Last																○
First																
Middle																○
Suffix																○

CONTACT INFORMATION *[Optional]*

Phone Number															
Email															
Current Address (if applicable)															
Street															
City															
State									Zip Code						

HOUSING STATUS AT EXIT *[All Clients]*

○	Homeless	○	Fleeing domestic violence	○	Client doesn't know
○	At imminent risk of losing housing	○	At-risk of homelessness	○	Client refused
○	Homeless only under other federal statutes	○	Stably housed	○	Data not collected

DESTINATION *[Head of Household and Adults]*

○	Deceased	○	Rental by client, with VASH housing subsidy
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher	○	Rental by client, with GPD TIP housing subsidy
○	Foster care home or foster care group home	○	Rental by client, with other ongoing housing subsidy
○	Hospital or other residential nonpsychiatric medical facility	○	Residential project or halfway house with no homeless criteria
○	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 ongoing housing subsidy	○	Transitional housing for homeless persons (including homeless youth)
○	Permanent housing for formerly homeless persons (such as: CoC project; or HUD legacy programs; or HOPWA PH)	○	Interim Housing
		○	No exit interview completed
○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bust/train/ airport or anywhere outside)	○	Client doesn't know
		○	Client refused
○	Psychiatric hospital or other psychiatric facility	○	Data not collected
○	Rental by client, no ongoing housing subsidy	○	**Other Specify**

IN PERMANENT HOUSING *[RRH PROGRAMS ONLY All Clients]*

○	Yes	○	No
IF "YES" TO PERMANENT HOUSING			
Date of MoveIn		____/____/_____	

INCOME FROM ANY SOURCE *[Head of Households and Adults]*

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

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY

	Income Source	**Amount**		**Income Source**	**Amount**
○	Earned Income		○	TANF (Temporary Assistance for Needy Families)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement Income from Social Security	
○	Social Security Disability Income (SSDI)		○	Pension or retirement income from former job	
○	VA Service-Connected Disability Compensation		○	Child support	
○	VA NonService Connected Disability Pension		○	Alimony and other spousal support	
○	Private disability insurance		○	Other source	
○	Worker's Compensation		**Specify "Other"**		
Total monthly amount:					

RECEIVING NONCASH BENEFITS *[Head of Household and Adults]*

○	No	○	Client doesn't know

○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO NONCASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	SNAP	○	Other TANF Benefit
○	WIC	○	Section 8
○	TANF Childcare	○	Temporary Rental Assistance
○	TANF Transportation	○	Other source
Specify "Other"			

COVERED BY HEALTH INSURANCE *[All Clients]*

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

IF "YES" TO HEALTH INSURANCE HEALTH INSURANCE COVERAGE DETAILS			
○	MEDICAID	○	Employer Provided
○	MEDICARE	○	Obtained through COBRA
○	SCHIP	○	Private Pay Health Insurance
○	VA Medical	○	State Health Insurance for Adults
○	Other (specify)	○	Indian Health Services Program

Signature of applicant stating all information is true and correct Date