Agency's LOGO

Head of Household Name: ___________________________

Universal Exit Form

Head of Household

HMIS CLIENT ID#	EXIT DATE
FILL-IN AFTER SERVICEPOINT ENTRY	MONTH / DAY / YEAR

REASON FOR LEAVING

- ☐ Completed Program
- ☐ Criminal activity / violence
- ☐ Death
- ☐ Disagreement with rules/persons
- ☐ End of Shelter Season (ES only)
- ☐ Left for housing opp. before completing program
- ☐ Needs could not be met
- ☐ Non-compliance with program
- ☐ Non-payment of rent
- ☐ Reached maximum time allowed
- ☐ Unknown/Disappeared
- ☐ Moved from Service Area
- ☐ No Client Contact
- ☐ Voluntary Departure (IDHS)
- ☐ Unable to Identify Housing (RRH)
- ☐ Permanent to Permanent transfer (including RRH)
- ☐ No longer meets population criteria
- ☐ Other: ______________________________________

DESTINATION

Homeless Situation

- ☐ 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, or RHY-funded Host Home shelter
- ☐ Safe Haven

Institutional Situation

- ☐ 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

Temporary or Permanent Housing Situation

- ☐ Residential or halfway house with no homeless criteria
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Host home (non-crisis)
- ☐ Staying or living with friends, temporary tenure (e.g., room, apartment or house)
- ☐ Staying or living with family, temporary tenure (e.g., room, apartment or house)
- ☐ Staying or living with family, permanent tenure
- ☐ Staying or living with friends, permanent tenure
- ☐ Moved from one HOPWA funded project to HOPWA PH
- ☐ Moved from one HOPWA funded project to HOPWA TH
- ☐ Rental by client with GPD TIP housing subsidy
- ☐ Rental by client, with VASH housing subsidy
- ☐ Permanent housing (other than RRH) for formerly homeless persons
- ☐ Rental by client, with RRH or equivalent subsidy
- ☐ Rental by client, with Housing Choice Voucher (HCV) (tenant or project based)
- ☐ Rental by client in a public housing unit
- ☐ Rental by client, no ongoing housing subsidy
- ☐ Rental by client, with other ongoing housing subsidy
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

Other

- ☐ No exit interview completed
- ☐ Deceased
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Data not collected
- ☐ Other:_______________________

Edited: 10/30/2019

Agency's LOGO

Northeast Illinois HMIS
A partnership between DuPage & Suburban Cook Counties

DUPAGECOUNTY CONTINUUM OF CARE
Working to end homelessness

Head of Household Name: ____________________________

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

☐ Yes ☐ No ☐ Doesn't Know ☐ Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
Alcohol Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Both Alcohol and Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Chronic Health Condition ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Developmental Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			

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DUPAGECOUNTY CONTINUUM OF CARE
Working to end homelessness

Head of Household Name: ___________________________

INCOME

Does the household have any current income?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

If No, move on to Household Income for AMI Below:

If Yes, indicate in each source if the household receives the income, and if they do, the household member receiving the income, the monthly amount (to the nearest dollar) of each source, and the income start date.

		HH Member	Amount	Start Date	HH Member	Amount	Start Date
Earned Income							
☐ Yes ☐ No	If Yes:		$			$	
			$			$	
Unemployment Insurance							
☐ Yes ☐ No	If Yes:		$			$	
SSI: Supplemental Security Income							
☐ Yes ☐ No	If Yes:		$			$	
Social Security Disability Income							
☐ Yes ☐ No	If Yes:		$			$	
VA Service Connected							
☐ Yes ☐ No	If Yes:		$			$	
Private Disability Insurance							
☐ Yes ☐ No	If Yes:		$			$	
Worker's Compensation							
☐ Yes ☐ No	If Yes:		$			$	
Temporary Assistance for Needy Families (TANF)							
☐ Yes ☐ No	If Yes:		$			$	
General Assistance							
☐ Yes ☐ No	If Yes:		$			$	
Retirement Income from Social Security							
☐ Yes ☐ No	If Yes:		$			$	
VA Non-Service Connected Disability Pension							
☐ Yes ☐ No	If Yes:		$			$	
Pension or retirement income from another job							
☐ Yes ☐ No	If Yes:		$			$	
Child Support							
☐ Yes ☐ No	If Yes:		$			$	
Alimony or Other Spousal Support							
☐ Yes ☐ No	If Yes:		$			$	
Other Source (specify):							
☐ Yes ☐ No	If Yes:		$			$	

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Head of Household Name: ____________________________

TOTAL MONTHLY HOUSEHOLD INCOME $________________ **NUMBER OF HOUSEHOLD MEMBERS** ________

FY2019 AREA MEDIAN INCOME (AMI)

Household Size	1	2	3	4	5	6	7	8
30% AMI	$1,563	$1,783	$2,008	$2,229	$2,408	$2,588	$2,767	$2,946
50% AMI	$2,600	$2,971	$3,342	$3,713	$4,013	$4,308	$4,604	$4,904
80% AMI	$4.163	$4,754	$5.350	$5,942	$6,421	$6,896	$7.371	$7,846
100% AMI	$5,200	$5,942	$6,683	7,425	$8,025	$8,617	$9,208	$9,808

TOTAL MONTHLY HOUSEHOLD INCOME AS PERCENTAGE OF AMI:

☐ Below 30% ☐ 30%-49% ☐ Greater than 50%

NON-CASH BENEFITS

Does the household currently receive any Non-Cash Benefits?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

Please indicate which of the following non-cash benefits have you received over the last 30 days.
(You may use "All" if all household members receive the benefit)

Food stamps or money for food on a benefits card (If yes, amount of benefit)	
☐ Yes ☐ No	If Yes, Household Members:
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
☐ Yes ☐ No	If Yes, Household Members:
TANF child care services	
☐ Yes ☐ No	If Yes, Household Members:
TANF transportation services	
☐ Yes ☐ No	If Yes, Household Members:
Other TANF-Funded Services	
☐ Yes ☐ No	If Yes, Household Members:
Other Source (specify):	
☐ Yes ☐ No	If Yes, Household Members:

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Head of Household Name: ___________________________

HEALTH INSURANCE

Do household members currently have health insurance?

☐ Yes ☐ No ☐ Client Does Not Know ☐ Client Refused

Complete the following *(You may use "All" if all household members receive the benefit)*

Medicaid	
☐ Yes ☐ No	If Yes, Household Members:
Medicare	
☐ Yes ☐ No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
☐ Yes ☐ No	If Yes, Household Members:
Veteran's Administration Medical Services	
☐ Yes ☐ No	If Yes, Household Members:
Employer Provided Health Insurance	
☐ Yes ☐ No	If Yes, Household Members:
Health Insurance obtained through COBRA	
☐ Yes ☐ No	If Yes, Household Members:
Private Pay Health Insurance	
☐ Yes ☐ No	If Yes, Household Members:
State Health Insurance for Adults	
☐ Yes ☐ No	If Yes, Household Members:
Indian Health Services Program	
☐ Yes ☐ No	If Yes, Household Members:
Other	
☐ Yes ☐ No	If Yes, Household Members:
If "Yes" to Other, Specify Source:	

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Head of Household Name: ___________________________

CLIENT'S RESIDENCE/LAST PERMANENT ADDRESS

For SSVF Projects, this is where the client lived for 90 days or more before coming to your project

Client's Street Address				Apt #	
City, Township		State		Zip	
Address Data Quality	☐ Full Address Reported ☐ Client Does Not Know	☐ Incomplete or estimated address reported ☐ Client Refused			
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	☐ After Program ☐ Before Program-Last Permanent	☐ Before Program ☐ Program (while in your project)			

EMERGENCY CONTACT (OPTIONAL)

Contact's Name					
Client's Street Address				Apt #	
City, Township		State		ZIP	
Phone #		Second Phone #			
Relationship to Client					
Start Date		End Date			
Is there a release of information to contact this person?	☐ Yes ☐ No				

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Head of Household Name: ___________________________

Universal Exit Form

Household Member

HMIS CLIENT ID#	EXIT DATE
FILL-IN AFTER SERVICEPOINT ENTRY	MONTH / DAY / YEAR

REASON FOR LEAVING

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☐ Left for housing opp. before completing program
☐ Needs could not be met
☐ Non-compliance with program
☐ Non-payment of rent
☐ Reached maximum time allowed
☐ Unknown/Disappeared
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☐ No Client Contact
☐ Voluntary Departure (IDHS)
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DESTINATION

Homeless Situation

☐ 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, or RHY-funded Host Home shelter
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Institutional Situation

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☐ Owned by client, no ongoing housing subsidy

Other

☐ No exit interview completed
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☐ Client doesn't know
☐ Client refused
☐ Data not collected
☐ Other:________________________

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DUPAGE COUNTY CONTINUUM OF CARE
Working to end homelessness

Head of Household Name: ___________________________

DISABILITY

Does the client have a disabling condition? *If the disability response changes during program participation contact the HMIS Help Desk for steps on how to complete the update.*

☐ Yes ☐ No ☐ Doesn't Know ☐ Refused

Disability Type	(If Yes) Start Date	Currently receiving Services or Treatment?	Will the Condition be long term?	Disability Determination
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	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
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	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Drug Abuse ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
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HIV/AIDS ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Mental Health Problem ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			
Physical Disability ☐ Yes ☐ No ☐ Client doesn't know ☐ Client Refused	______/______/______	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused	☐ Yes ☐ No	☐ Yes ☐ Doesn't Know ☐ No ☐ Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	☐ Yes ☐ No ☐ Client Doesn't Know ☐ Client Refused		
	Notes:			