

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

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

DESTINATION

Homeless Situation	Temporary or 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, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven Institutional Situation <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"/> Residential or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) <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"/> Moved from one HOPWA funded project to HOPWA TH <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> No exit interview completed <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Other: _____

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			

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								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
				\$			\$	
Unemployment Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
SSI: Supplemental Security Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Social Security Disability Income								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Service Connected								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Private Disability Insurance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Worker's Compensation								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Temporary Assistance for Needy Families (TANF)								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
General Assistance								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Retirement Income from Social Security								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
VA Non-Service Connected Disability Pension								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Pension or retirement income from another job								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Child Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Alimony or Other Spousal Support								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	
Other Source (specify):								
<input type="checkbox"/> Yes	<input type="checkbox"/> No	If Yes:		\$			\$	

Agency's LOGO



Head of Household Name: _____

TOTAL MONTHLY HOUSEHOLD INCOME \$ _____ **NUMBER OF HOUSEHOLD MEMBERS** _____

FY2020 AREA MEDIAN INCOME (AMI)

Household Size	1	2	3	4	5	6	7	8
30% AMI	\$1,596	\$1,821	\$2,050	\$2,275	\$2,458	\$2,642	\$2,825	\$3,004
50% AMI	\$2,654	\$3,033	\$3,413	\$3,792	\$4,096	\$4,400	\$4,704	\$5,008
80% AMI	\$4,250	\$4,854	\$5,463	\$6,067	\$6,554	\$7,038	\$7,525	\$8,008
100% AMI	\$5,308	\$6,067	\$6,825	\$7,583	\$8,192	\$8,667	\$9,408	\$10,017

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)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF child care services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
TANF transportation services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other TANF-Funded Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other Source (specify):	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Medicare	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Illinois All Kids (State Children's Health Insurance Program)	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Veteran's Administration Medical Services	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Employer Provided Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Health Insurance obtained through COBRA	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Private Pay Health Insurance	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
State Health Insurance for Adults	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Indian Health Services Program	
<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Household Members:
Other	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/> Full Address Reported <input type="checkbox"/> Client Does Not Know		<input type="checkbox"/> Incomplete or estimated address reported <input type="checkbox"/> Client Refused		
Phone Number		Alternate Phone			
Email Address					
Start Date		End Date			
Client's Residence Notes					
Address Type	<input type="checkbox"/> After Program <input type="checkbox"/> Before Program-Last Permanent		<input type="checkbox"/> Before Program <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> 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

- 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	Temporary or 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, or RHY-funded Host Home shelter <input type="checkbox"/> Safe Haven Institutional Situation <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"/> Residential or halfway house with no homeless criteria <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Host home (non-crisis) <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) <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"/> Moved from one HOPWA funded project to HOPWA TH <input type="checkbox"/> Rental by client with GPD TIP housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, with Housing Choice Voucher (HCV) (tenant or project based) <input type="checkbox"/> Rental by client in a public housing unit <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	<input type="checkbox"/> No exit interview completed <input type="checkbox"/> Deceased <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> Data not collected <input type="checkbox"/> Other: _____

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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Both Alcohol and Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Chronic Health Condition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Developmental Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Drug Abuse <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Mental Health Problem <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			
Physical Disability <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client Refused	____/____/____	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Doesn't Know <input type="checkbox"/> No <input type="checkbox"/> Refused
	If Yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client Refused	
	Notes:			