ICA Missouri – HOPWA Exit – TH [FY2026] Adult/HoH

Staff: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Project Exit Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_ Name of Head of Household:

Project Name (Enter Data As):

**Client Record**

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| 🛈 | Unless specifically required by a funder, clients may use a preferred name (rather than legal name) for HMIS purposes. |

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| **Client** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  | Name | Client ID |

**Reason for Leaving**

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| --- | --- |
| □ Completed program  □ Criminal activity / violence  □ Death  □ 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 (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Reached maximum time allowed  □ Unknown/disappeared |

**Destination**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| |  |  | | --- | --- | | **Homeless situations** | | | □ 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 | | | **Institutional situations** | | | □ 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 housing situations** | | | □ Residential project 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 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 | | **Permanent housing situations (if none of these options match, skip to “Other”)** | | | □ 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 subsidy *(select subsidy type 🡺)*  □ Owned by client, with ongoing housing subsidy  □ Owned by client, no ongoing housing subsidy | *If “rental by client, with ongoing subsidy”, select type*  □ GPD TIP housing subsidy  □ VASH housing subsidy  □ RRH or equivalent subsidy  □ HCV Voucher (tenant or project based)  □ Public housing unit  □ Rental by client, with other ongoing housing subsidy  □ Housing Stability Voucher  □ Family Unification Program Voucher (FUP)  □ Foster Youth to Independence Initiative (FYI)  □ Permanent Supportive Housing  □ Other permanent housing dedicated for formerly homeless persons | | | **Other** | | | □ No exit interview completed  □ Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  □ Deceased | □ Client doesn't know  □ Client prefers not to answer | |
|  |

**Client location as of assessment/review date**

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| --- | --- |
| 🛈 | Select the county in which the client is residing (or sleeping at night if unhoused). This field does not need to match the CoC Code above. |

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| **Client Location (County)** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Housing Assessment at Exit**

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| --- | --- |
| **Housing Assessment at Exit** | □ Able to maintain the housing they had at project entry  □ Moved to new housing unit  □ Moved in with family/friends on a temporary basis  □ Moved in with family/friends on a permanent basis  □ Moved to a transitional or temporary housing facility or program  □ Client became homeless – moving to a shelter or other place unfit for human habitation  □ Jail/prison  □ Deceased  □ Client doesn’t know  □ Client prefers not to answer |
| **If “able to maintain the housing  they had at project entry”,  subsidy information:** | □ Without a subsidy  □ With the subsidy they had at project entry  □ With an ongoing subsidy acquired since project entry  □ Only with financial assistance other than a subsidy |
| **If “moved to a new housing unit,” subsidy information:** | □ With ongoing subsidy  □ Without an ongoing housing subsidy |

**Health Insurance**

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| --- | --- | --- | --- | --- |
| **Covered by Health Insurance** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

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| --- | --- | --- | --- | --- | --- |
| Medicaid (MO HealthNet) | □ No | □ Yes |  |  |  |
| Medicare | □ No | □ Yes |  | 🛈 | HUD requires that the client be asked about  each individual source of health insurance  and requires an answer be recorded for each. |
| State Children’s Health Insurance Program | □ No | □ Yes |  |
| Veteran’s Administration (VA) Medical Services | □ No | □ Yes |  |
| Employer-Provided Health Insurance | □ No | □ Yes |  |  |  |
| Health Insurance obtained through COBRA | □ No | □ Yes |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of health insurance changes. |
| Private Pay Health Insurance | □ No | □ Yes |  |
| State Health Insurance for Adults | □ No | □ Yes |  |
| Indian Health Services Program | □ No | □ Yes |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Yes |  |  |  |

**Monthly Income**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Income from Any Source** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

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| --- | --- | --- | --- | --- | --- |
| Alimony and other spousal support | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Child support | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🛈 | HUD requires that the client be  asked about each individual source  of income and requires an answer  be recorded for each.  For any income sources where income  is received, the monthly amount must  also be recorded. |
| Earned income (i.e., employment income) | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| General Assistance (GA) | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Pension or retirement income from a former job | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Private disability insurance | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Retirement Income from Social Security | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Social Security Disability Insurance (SSDI) | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of income changes. |
| Supplemental Security Income (SSI) | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Temporary Assistance for Needy Families (TANF) | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| Unemployment Insurance | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| VA Non-Service-Connected Disability Pension | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| VA Service-Connected Disability Compensation | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Worker’s Compensation | □ No | □ Yes: $\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

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| --- | --- | --- | --- | --- |
| **Total Monthly Income** | $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |

**Non-Cash Benefits**

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| --- | --- | --- | --- | --- |
| **Non-Cash Benefits from Any Source** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |

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| Supplemental Nutrition Assistance Program (SNAP)  (Previously known as Food Stamps) | □ No | □ Yes |  | 🛈 | HUD requires that the client be  asked about each individual source  of non-cash benefits and requires  an answer be recorded for each. |
| Special Supplemental Nutrition Program for  Women, Infants and Children (WIC) | □ No | □ Yes |  |
| TANF Child Care services | □ No | □ Yes |  |  |  |
| TANF transportation services | □ No | □ Yes |  | 🛈 | **Data Entry Tip:**  Remember to end date old records  and create new records each time  a source of non-cash benefit changes. |
| Other TANF-funded services | □ No | □ Yes |  |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | □ No | □ Yes |  |

**Disabilities**

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| --- | --- |
| 🛈 | If one or more of the options below with an asterisk(\*) has been selected, the answer to “disabling condition” must be “yes.”  If none of the answers below with an asterisk(\*) has been selected, the answer to “disabling condition” may be “yes” or “no.” |

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| --- | --- | --- |
| Disability type | Disability determination | If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? |
| Alcohol Use Disorder | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Both Alcohol and Drug Use Disorders | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Chronic Health Condition | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Developmental Disability | □ Yes\* □ No □ DK □ PNTA | *(not applicable)* |
| Drug Use Disorder | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| HIV/AIDS | □ Yes\* □ No □ DK □ PNTA | *(not applicable)* |
| Mental Health Disorder | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |
| Physical Disability | □ Yes □ No □ DK □ PNTA | □ Yes\* □ No □ DK □ PNTA |

DK = Client doesn’t know; PNTA = Client prefers not to answer

**Medical Assistance [Persons with HIV/AIDS Only]**

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| **Receiving AIDS Drug Assistance Program (ADAP)** | □ No | □ Yes | □ Client doesn’t know | | □ Client prefers not to answer |
| **If no, reason** | □ Applied; decision pending  □ Applied; client not eligible  □ Client did not apply | | | □ Insurance type N/A for this client  □ Client doesn’t know  □ Client prefers not to answer | |

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| --- | --- | --- | --- | --- | --- |
| **Receiving Ryan White-funded Medical or Dental Assistance** | □ No | □ Yes | □ Client doesn’t know | | □ Client prefers not to answer |
| **If no, reason** | □ Applied; decision pending  □ Applied; client not eligible  □ Client did not apply | | | □ Insurance type N/A for this client  □ Client doesn’t know  □ Client prefers not to answer | |

**T-Cell (CD4) and Viral Load [Persons with HIV/AIDS Only]**

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| **T-Cell (CD4) Count Available** | □ No | □ Yes | | □ Client doesn’t know | | □ Client prefers not to answer |
| **If yes, T-Cell Count:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (0-1500) | | | | | |
| **If yes, how was the information obtained?** | □ Medical report | | □ Client report | | □ Other | |

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| **Viral Load Information Available** | □ No | □ Yes | | □ Client doesn’t know | | □ Client prefers not to answer |
| **If yes, count:** | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (0-999999) | | | | | |
| **If yes, how was the information obtained?** | □ Medical report | | □ Client report | | □ Other | |

**Prescribed Anti-Retroviral [Persons with HIV/AIDS Only]**

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| --- | --- | --- | --- | --- |
| **Has the participant been prescribed anti-retroviral drugs?** | □ No | □ Yes | □ Client doesn’t know | □ Client prefers not to answer |