**Services Only Individual Discharge Form**

**Applicant (Head of Household) Information:**

**First Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Client ID#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Project Exit Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Case Manager Assigned to Discharge**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Destination Type:**

🞎 🞎 Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/

airport or anywhere outside)

🞎 Safe Haven

🞎 Psychiatric Hospital or other psychiatric facility

🞎 Substance Abuse treatment facility or detox center

🞎 Hospital or other residential non-psychiatric

medical facility

🞎 Jail, prison, or juvenile detention facility

🞎 Foster care or foster care group Home

🞎 Long-term care facility or Nursing Home

🞎 Transitional housing for homeless persons

(including homeless youth)

🞎 Rental by client, no ongoing housing subsidy

🞎 Owned by client, no ongoing housing subsidy

🞎 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)

🞎 Hotel or Motel paid for without Emergency Shelter voucher

🞎 Rental by client, with ongoing housing

Subsidy

**IF *Rental by client, with ongoing housing***

***Subsidy is Checked*, Please select Subsidy from List:**

🞎 *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*

🞎 *Emergency Housing Voucher*

🞎 *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

🞎 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

🞎 Residential Project or hallway house with no homeless criteria

🞎 Host Home (non-crisis)

------------------------------------------------------------

🞎 Other

🞎 Deceased

🞎 No exit interview completed

🞎 Client doesn't know

🞎 Client Prefers Not to Answer

🞎 Data Not Collected

If Other, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Shared Housing Information:**

*(Shared housing means clients will be on separate leases or living as roommates. Not clients living together as a couple)***:**

**Is this a Shared Housing Destination (separate leases)?** 🞎 Yes 🞎 No

***If Yes,***

 **Shared Housing Facilitated by:?** 🞎 CAN 🞎 Client

**Non-Cash Benefit from any source?** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

**If “YES” Check those that apply:**

🞎 Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)

🞎 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

🞎 TANF Child Care Services

🞎 TANF Transportation services

🞎 Other TANF-funded services

🞎 Other Source

**Covered by Health Insurance:** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

**Disabling Conditions:**

|  |  |
| --- | --- |
|  | **Head of Household** |
| **Disabling Condition** (All Adults)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* | **N/A** |
| **Physical Disability** (All Clients)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| **Developmental Disability** (All Clients)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| If yes, Expected to substantially impair ability to live independently? *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| **Chronic Health Condition** (All Clients)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| If yes, expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| **HIV/AIDS** (All Clients)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| If yes, Expected to substantially impair ability to live independently? *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| **Mental Health Disorder** (All Clients)*No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| If yes, Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently? *No, Yes, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| **Substance Abuse Disorder** (All Clients)*No, Alcohol Abuse, Drug Abuse, Both Alcohol and Drug, Client Doesn’t Know, Client Prefers Not to Answer, Data Not Collected* |  |
| 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 Prefers Not to Answer* |  |

**Translation Assistance:**

**Translation Assistance Needed?** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected

*If yes,* Preferred Language*: ­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Health Insurance:**

|  |  |
| --- | --- |
| **Type of Insurance** | **Check which ever applies** |
| Medicaid / HUSKY A, C, D | 🞎 |
| Medicare | 🞎 |
| State Children’s Health Insurance Program – HUSKY B | 🞎 |
| Veteran’s Health Administration (VHA) | 🞎 |
| Employer-Provided Health Insurance | 🞎 |
| Health Insurance Obtained through COBRA | 🞎 |
| Private Pay Health Insurance | 🞎 |
| Indian Health Services Program | 🞎 |
| State Health Insurance for Adults  | 🞎 |
| Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 |

**Income**

**Income received from any source (HOH and Adults only)?** 🞎 No 🞎 Yes 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer🞎 Data Not Collected

|  |  |
| --- | --- |
|  | **Head of Household** |
| **Income Type** | Monthly Amount |
| Unemployment Insurance |  |
| Earned Income (i.e. Employment income) |  |
| Supplemental Security income (SSI) |  |
| Social Security Disability Income (SSDI) |  |
| VA Service Connected Disability Compensation |  |
| Private Disability Insurance |  |
| Temporary Assistance for Needy Families (TANF) |  |
| General Assistance (GA) |  |
| Retirement Income and Social Security |  |
| VA Non-Service-Connected Disability Pension |  |
| Pension or retirement income from another job |  |
| Child Support |  |
| Alimony or other spousal support |  |
| Worker's Compensation |  |
| Other Source |  |
| **Client Income Total:** |  |