**DOH AIDS/HOPWA Family Discharge Form**

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

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

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Household Member Name** |  | **Date of Birth** | **Sex:** 🞎 Male 🞎 Female 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected | **Relationship to Head of Household** |
| **HMIS ID#** |
|  |  |  |  | **Self** |
|  |  |  |  |  |
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|  |  |  |  |  |

**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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

🞎 Client doesn’t know

🞎 Client Prefers Not to Answer

🞎 Deceased

🞎 Data not collected

*If Able to maintain the housing they had at project entry:*

**Same Housing Subsidy Info:**

🞎 Without a subsidy

🞎 With the subsidy they had at project entry

🞎 With an on-going subsidy acquired since project entry

🞎 Only with financial assistance other than a subsidy

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

*Non-cash benefits received by or on behalf of a minor child should be recorded as part of the household income under the Head of Household.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Head of Household** | **Member 2** | **Member 3** | **Member 4** | **Member 5** |
|  | **YES / NO** | **YES / NO** | **YES / NO** | **YES / NO** | **YES / NO** |
| (SNAP) Food Stamps |  |  |  |  |  |
| Special Supplemental Nutrition Program for WIC |  |  |  |  |  |
| TANF Child Care Services |  |  |  |  |  |
| TANF Transportation |  |  |  |  |  |
| Other TANF Funded Services |  |  |  |  |  |
| Client Doesn't know |  |  |  |  |  |
| Client Prefers Not to Answer |  |  |  |  |  |
| Other (Please Specify): |  |  |  |  |  |

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

**Disabling Conditions (All Clients)**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Head of Household** | **Member 2** | **Member 3** | **Member 4** | **Member 5** |
| **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* |  |  |  |  |  |
| **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* |  |  |  |  |  |
| **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 Use Disorder** (All Clients)  *No, Alcohol Use, Drug Use, Both Alcohol and Drug Use, 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 (*All clients*):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Head of Household (HOH)** | **Member 2** | **Member 3** | **Member 4** | **Member 5** |
| 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If Other, Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | 🞎 MEDICAID  🞎 MEDICARE  🞎 State Children’s Health Insurance Program  🞎 Veteran’s Health Administration (VHA)  🞎 Employer-Provided Health Insurance  🞎 Health Insurance obtained through COBRA  🞎 State Health Insurance for Adults  🞎 Private Pay Health Insurance  🞎 Indian Health Services Program  🞎 Other  If 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

\*Note: *Income received by or on behalf of a minor child should be recorded as part of the household income under the Head of Household****.***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **Head of Household** | **HH Member 1** | **HH Member 2** | **HH Member 3** | **HH Member 4** |
| **Income Type** | Monthly Amount | Monthly Amount | Monthly Amount | Monthly Amount | 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:** |  |  |  |  |  |

**Receiving AIDS Drug Assistance Program (ADAP)?** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected

**If No to “Receiving AIDS Drug Assistance Program (ADAP)” Reason**

|  |  |
| --- | --- |
| 🞎 Applied; decision pending | 🞎 Insurance type N/A for this client |
| 🞎 Applied; client not eligible | 🞎 Client doesn't know |
| 🞎 Client did not apply | 🞎 Client Prefers Not to Answer  🞎 Data Not Collected |
|  |  |

**Receiving Ryan White-funded Medical or Dental Assistance?:** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer

**If No for “Receiving Ryan White-funded Medical or Dental Assistance” Reason**

|  |  |
| --- | --- |
| 🞎 Applied; decision pending | 🞎 Insurance type N/A for this client |
| 🞎 Applied; client not eligible | 🞎 Client doesn't know |
| 🞎 Client did not apply | 🞎 Client Prefers Not to Answer |

**Has the client been prescribed anti-retroviral drugs?:** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer

**T-Cell (CD4) Count Available:** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected

*If yes,* **T-cell Count: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How was the T-cell count information obtained?** 🞎 Medical Report 🞎 Client Report 🞎 Other

**Viral Load Information Available:** 🞎 Yes 🞎 No 🞎 Client doesn’t know 🞎 Client Prefers Not to Answer 🞎 Data Not Collected

***If Available:* Viral Load Count: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How was the viral load information obtained?** 🞎 Medical Report 🞎 Client Report 🞎 Other