

HMIS DISCHARGE

FIRST NAME	LAST NAME	BIRTHDATE
GENDER		
<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Other
		<input type="checkbox"/> Trans F to M
<input type="checkbox"/> Trans M to F		

PROJECT	DISCHARGE DATE
REASON FOR DISCHARGE	
<input type="checkbox"/> Left for a housing opportunity before completing program <input type="checkbox"/> Non-payment of rent/occupancy charge <input type="checkbox"/> Criminal activity / destruction of property / violence <input type="checkbox"/> Needs could not be met by project <input type="checkbox"/> Death	<input type="checkbox"/> Completed program <input type="checkbox"/> Non-compliance with project <input type="checkbox"/> Reached maximum time allowed in project <input type="checkbox"/> Disagreement with rules/persons <input type="checkbox"/> Unknown/disappeared
<input type="checkbox"/> Other: _____	

INCOME FROM ANY SOURCE (monthly) (Head of Household and Adult only)	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
IF YES:	
<input type="checkbox"/> Earned Income..... \$ _____ <input type="checkbox"/> SSI \$ _____ <input type="checkbox"/> VA Service-Connected Disability Compensation \$ _____ <input type="checkbox"/> Private Disability Insurance..... \$ _____ <input type="checkbox"/> TANF \$ _____ <input type="checkbox"/> Retirement from SSA..... \$ _____ <input type="checkbox"/> Child Support \$ _____ <input type="checkbox"/> Other (specify) \$ _____	<input type="checkbox"/> Unemployment Insurance.....\$ _____ <input type="checkbox"/> SSDI\$ _____ <input type="checkbox"/> VA Non-Service Connected Disability Pension.....\$ _____ <input type="checkbox"/> Worker's Compensation\$ _____ <input type="checkbox"/> General Public Assistance.....\$ _____ <input type="checkbox"/> Pension or Retirement from former job.....\$ _____ <input type="checkbox"/> Alimony or Other Spousal Support\$ _____

NON CASH BENEFITS FROM ANY SOURCE	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
IF YES:	
<input type="checkbox"/> SNAP (Food Stamps) <input type="checkbox"/> TANF Child Care Services <input type="checkbox"/> Section 8, Public Housing or Other Ongoing Rental Assistance <input type="checkbox"/> Other Source	<input type="checkbox"/> Special Supplemental Nutrition Program for Women, Infants and Children (WIC) <input type="checkbox"/> TANF Transportation Services <input type="checkbox"/> Other TANF Funded Services <input type="checkbox"/> Temporary Rental Assistance

COVERED BY HEALTH INSURANCE	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
IF YES:	
MEDICAID <input type="checkbox"/> No <input type="checkbox"/> Yes State Children's Health Insurance Program <input type="checkbox"/> No <input type="checkbox"/> Yes Employer provided Health insurance <input type="checkbox"/> No <input type="checkbox"/> Yes Private Pay Health Insurance..... <input type="checkbox"/> No <input type="checkbox"/> Yes	MEDICARE..... <input type="checkbox"/> No <input type="checkbox"/> Yes VA Medical Services..... <input type="checkbox"/> No <input type="checkbox"/> Yes Health ins. via COBRA <input type="checkbox"/> No <input type="checkbox"/> Yes State Health Ins. Adults <input type="checkbox"/> No <input type="checkbox"/> Yes

PHYSICAL DISABILITY	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
IF YES:	
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes	
Received services/treatment while in the program:	
<input type="checkbox"/> No	<input type="checkbox"/> Yes
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused
<input type="checkbox"/> Data Not Collected	

DEVELOPMENTAL DISABILITY				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to substantially impair ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Received services/treatment while in the program:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

CHRONIC HEALTH CONDITION				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Received services/treatment while in the program:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

HIV/AIDS				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to substantially impair ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Received services/treatment while in the program:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

MENTAL HEALTH PROBLEM				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Received services/treatment while in the program:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

SUBSTANCE ABUSE PROBLEM				
<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Both Alcohol and Drug Abuse		
<input type="checkbox"/> No	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected	
IF YES:				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
Documentation of the disability and severity on file: <input type="checkbox"/> No <input type="checkbox"/> Yes				
Received services/treatment while in the program:				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected

DOMESTIC ABUSE VICTIM/SURVIVOR (Head of Household and Adult only)				
<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected
IF YES: WHEN DID THE EXPERIENCE OCCUR?				
<input type="checkbox"/> 1 day or less	<input type="checkbox"/> 2 days to 1 week	<input type="checkbox"/> More than 1 week but less than 1 month		
<input type="checkbox"/> 1 to 3 months	<input type="checkbox"/> More than 3 months, less than 1 year	<input type="checkbox"/> 1 year or longer		
<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Data Not Collected		

DESTINATION (Head of Household and Adult only)	
<input type="checkbox"/> Deceased <input type="checkbox"/> Emergency shelter, including hotel or motel paid for with emergency shelter voucher <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"/> Hotel or Motel paid for without emergency voucher <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Moved from a HOPWA funded project to HOPWA PH <input type="checkbox"/> Moved from a HOPWA funded project to HOPWA TH <input type="checkbox"/> Owned by client, no ongoing subsidy <input type="checkbox"/> Owned by client, with ongoing subsidy <input type="checkbox"/> Permanent housing for formerly homeless persons (such as SHP, S+C, or SRO Mod Rehab) <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"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Rental by client, with VASH subsidy <input type="checkbox"/> Rental by client, with GPD TIP subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Safe Haven <input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment or house) <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Transitional housing for homeless persons (including homeless youth) <input type="checkbox"/> Other (describe) _____ <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused <input type="checkbox"/> No exit interview completed <input type="checkbox"/> Data not collected

NEW RESIDENCE COUNTY					
<input type="checkbox"/> Albany	<input type="checkbox"/> Cortland	<input type="checkbox"/> Jefferson	<input type="checkbox"/> Onondaga	<input type="checkbox"/> St. Lawrence	<input type="checkbox"/> Ulster
<input type="checkbox"/> Allegany	<input type="checkbox"/> Delaware	<input type="checkbox"/> Kings	<input type="checkbox"/> Ontario	<input type="checkbox"/> Saratoga	<input type="checkbox"/> Warren
<input type="checkbox"/> Bronx	<input type="checkbox"/> Dutchess	<input type="checkbox"/> Lewis	<input type="checkbox"/> Orange	<input type="checkbox"/> Schenectady	<input type="checkbox"/> Washington
<input type="checkbox"/> Broome	<input type="checkbox"/> Erie	<input type="checkbox"/> Livingston	<input type="checkbox"/> Orleans	<input type="checkbox"/> Schoharie	<input type="checkbox"/> Wayne
<input type="checkbox"/> Cattaraugus	<input type="checkbox"/> Essex	<input type="checkbox"/> Madison	<input type="checkbox"/> Oswego	<input type="checkbox"/> Schuyler	<input type="checkbox"/> Westchester
<input type="checkbox"/> Cayuga	<input type="checkbox"/> Franklin	<input type="checkbox"/> Monroe	<input type="checkbox"/> Otsego	<input type="checkbox"/> Seneca	<input type="checkbox"/> Wyoming
<input type="checkbox"/> Chautauqua	<input type="checkbox"/> Fulton	<input type="checkbox"/> Montgomery	<input type="checkbox"/> Putnam	<input type="checkbox"/> Steuben	<input type="checkbox"/> Yates
<input type="checkbox"/> Chemung	<input type="checkbox"/> Genesee	<input type="checkbox"/> Nassau	<input type="checkbox"/> Queens	<input type="checkbox"/> Suffolk	<input type="checkbox"/> NYS Unknown
<input type="checkbox"/> Chenango	<input type="checkbox"/> Greene	<input type="checkbox"/> New York	<input type="checkbox"/> Rensselaer	<input type="checkbox"/> Sullivan	<input type="checkbox"/> USA not NYS
<input type="checkbox"/> Clinton	<input type="checkbox"/> Hamilton	<input type="checkbox"/> Niagara	<input type="checkbox"/> Richmond	<input type="checkbox"/> Tioga	<input type="checkbox"/> Not USA
<input type="checkbox"/> Columbia	<input type="checkbox"/> Herkimer	<input type="checkbox"/> Oneida	<input type="checkbox"/> Rockland	<input type="checkbox"/> Tompkins	<input type="checkbox"/> Unknown

OUTCOME CATEGORY		
<input type="checkbox"/> Graduation	<input type="checkbox"/> Service Refusal / Drop Out	<input type="checkbox"/> Transfer to Similar Program
<input type="checkbox"/> Medical Complications / Deceased	<input type="checkbox"/> Suicide	<input type="checkbox"/> Other - Neutral
<input type="checkbox"/> Other - Negative	<input type="checkbox"/> Incarceration	<input type="checkbox"/> Long-Term Psych. Hospitalization

NOTES