

HMIS Data Collection Form – RHY MGH & TLP – Individuals

FOR USE BY RHY-FUNDED MATERNITY GROUP HOME, AND TRANSITIONAL LIVING PROGRAM PROJECTS THAT SERVE INDIVIDUALS

PROJECT START INFORMATION

ENTER DATA AS (EDA) PROJECT	PROJECT START DATE	CONSENT GIVEN FOR STATEWIDE DATA SHARING? <input type="checkbox"/> Yes (Use <i>shared</i> 500,000 ID in HMIS) <input type="checkbox"/> No (Use <i>unshared</i> record in HMIS)
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CLIENT HMIS RECORD IDENTIFIERS

FIRST NAME	MI	LAST NAME
ALIASES	SOCIAL SECURITY NUMBER <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer	US MILITARY VETERAN <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

FEDERAL REPORTING REQUIREMENTS

RELATIONSHIP TO HEAD OF HOUSEHOLD (HOH) <input type="checkbox"/> Self <input type="checkbox"/> HoH's child <input type="checkbox"/> HoH's other relation member <input type="checkbox"/> HoH's spouse or partner <input type="checkbox"/> Other: non-relation member <input type="checkbox"/> Unknown
ENROLLMENT COC <input type="checkbox"/> AK-500 Anchorage Continuum of Care <input type="checkbox"/> AK-501 Alaska Balance of State Continuum of Care

REFERRAL SOURCE INFORMATION

REFERRAL SOURCE <input type="checkbox"/> Self-Referral <input type="checkbox"/> Individual (parent, guardian, relative, friend) <input type="checkbox"/> Outreach Project (Answer below.) <input type="checkbox"/> Temporary Shelter <input type="checkbox"/> Residential Project <input type="checkbox"/> Hotline <input type="checkbox"/> School <input type="checkbox"/> Child Welfare / OCS <input type="checkbox"/> Mental Hospital <input type="checkbox"/> Other Organization <input type="checkbox"/> Juvenile Justice <input type="checkbox"/> Law Enforcement / Police	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to
If Outreach Project is the referral source, how many times was the client approached by outreach prior to entering the project?	

CLIENT DEMOGRAPHICS

DATE OF BIRTH <input type="checkbox"/> Full DOB <input type="checkbox"/> Partial DOB	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
RACE AND ETHNICITY <input type="checkbox"/> American Indian, Alaska Native, or Indigenous <input type="checkbox"/> Asian or Asian American <input type="checkbox"/> Black, African American, or African <input type="checkbox"/> Hispanic/Latina/e/o <input type="checkbox"/> Middle Eastern or North African <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Additional (specify):	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
GENDER <input type="checkbox"/> Woman (Girl, if child) <input type="checkbox"/> Man (Boy, if child) <input type="checkbox"/> Culturally Specific Identity (e.g., Two-Spirit) <input type="checkbox"/> Transgender <input type="checkbox"/> Non-Binary <input type="checkbox"/> Questioning <input type="checkbox"/> Different Identity (specify):	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
SEXUAL ORIENTATION (Heads of Household and Adults only) <input type="checkbox"/> Heterosexual/Straight <input type="checkbox"/> Gay <input type="checkbox"/> Lesbian <input type="checkbox"/> Bisexual <input type="checkbox"/> Questioning/Unsure <input type="checkbox"/> Other/Additional (specify to the right) →	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer <input type="checkbox"/> Aromantic <input type="checkbox"/> Asexual <input type="checkbox"/> Demisexual <input type="checkbox"/> Pansexual <input type="checkbox"/> Queer <input type="checkbox"/> Other (Ex: same gender-loving, stud)

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HEALTH INSURANCE COVERAGE INFORMATION

COVERED BY HEALTH INSURANCE?	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes (If yes, select answer for each type below.) <input type="checkbox"/> No (If no, answer No for all types in HMIS.)	

HEALTH INSURANCE TYPES (HUD TABLE)	Yes	No	HEALTH INSURANCE TYPES (HUD TABLE)	Yes	No
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	Health Insurance through COBRA	<input type="checkbox"/>	<input type="checkbox"/>
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	Private Pay Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
State Children's Health Insurance Program	<input type="checkbox"/>	<input type="checkbox"/>	State Health Insurance for Adults	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Health Administration	<input type="checkbox"/>	<input type="checkbox"/>	Indian Health Services Program	<input type="checkbox"/>	<input type="checkbox"/>
Employer-Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>

DISABLING CONDITION INFORMATION

DISABLING CONDITIONS?	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes (If yes, select answer for each type below.) <input type="checkbox"/> No (If no, answer No for all types in HMIS.)	

DISABLING CONDITIONS (HUD TABLE)	Yes	No	Doesn't know	Prefers not to answer		Yes	No	Doesn't know	Prefers not to answer
Alcohol Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	If Yes, does it affect their ability to live independently?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Both Alcohol and Drug Use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Health Condition	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Use Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
HIV / AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AK DISABLING CONDITIONS	Yes	No	Doesn't know	Prefers not to answer
Alzheimer's Disease and Related Dementias	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Alcoholism or other substance use disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intellectual or Developmental Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traumatic Brain Injuries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ALASKA NATIVE REGIONAL CORPORATION

PRIMARY REGIONAL CORPORATION	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Not Affiliated <input type="checkbox"/> Sealaska <input type="checkbox"/> Doyon Limited <input type="checkbox"/> Calista <input type="checkbox"/> Bering Straits Native <input type="checkbox"/> Ahtna <input type="checkbox"/> 13 th Regional <input type="checkbox"/> Koniag <input type="checkbox"/> Chugach Alaska <input type="checkbox"/> Cook Inlet Regional <input type="checkbox"/> Bristol Bay Native <input type="checkbox"/> Aleut <input type="checkbox"/> Arctic Slope Regional <input type="checkbox"/> NANA Regional	
SECONDARY REGIONAL CORPORATION, IF APPLICABLE:	

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PRIOR LIVING SITUATION INFORMATION (Heads of Household and Adults only)

TYPE OF RESIDENCE: LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START		<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
Homeless Situation	<input type="checkbox"/> Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent) <input type="checkbox"/> Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter		
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 use treatment facility or detox center		
Temporary Housing Situation	<input type="checkbox"/> Transitional housing for homeless persons youth (including homeless youth) <input type="checkbox"/> Residential project/halfway house with no homeless criteria <input type="checkbox"/> Hotel/motel paid for without ES voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living in friend's room, apartment, or house <input type="checkbox"/> Staying or living in family's room, apartment, or house		
Permanent Housing Situation	<input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with housing subsidy (specify to the right) → <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy	if Rental by client, with housing subsidy, specify only one: <input type="checkbox"/> GPD TIP <input type="checkbox"/> VASH <input type="checkbox"/> RRH or equivalent <input type="checkbox"/> Housing Choice (HCV) <input type="checkbox"/> Public housing <input type="checkbox"/> Other ongoing subsidy <input type="checkbox"/> Family Unification Program (FUP) <input type="checkbox"/> Foster Youth to Independence (FYI) <input type="checkbox"/> Permanent Supportive Housing (PSH) <input type="checkbox"/> Other PH dedicated to formerly homeless	

LENGTH OF STAY IN LIVING SITUATION IMMEDIATELY PRIOR TO PROJECT START	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> One night or less <input type="checkbox"/> One week or more, but less than a month <input type="checkbox"/> 90 days or more, but less than one year <input type="checkbox"/> Two to six nights <input type="checkbox"/> One month or more, but less than 90 days <input type="checkbox"/> One year or longer		

IF THE CLIENT IS CURRENTLY EXPERIENCING HOMELESSNESS, ANSWER THE FOLLOWING.

APPROXIMATE DATE THIS CURRENT EPISODE OF HOMELESSNESS STARTED
____/____/____

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF EPISODES OF HOMELESSNESS IN THE PAST THREE YEARS INCLUDING TODAY	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 1 time <input type="checkbox"/> 2 times <input type="checkbox"/> 3 times <input type="checkbox"/> 4 or more times		

IF THE CLIENT HAS EXPERIENCED HOMELESSNESS IN THE PAST THREE YEARS, ANSWER THE FOLLOWING.

NUMBER OF MONTHS HOMELESS IN THE PAST THREE YEARS INCLUDING THIS MONTH	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> 1 month (1 st month in the past 3 years) <input type="checkbox"/> 6 months <input type="checkbox"/> 10 months <input type="checkbox"/> 2 months <input type="checkbox"/> 7 months <input type="checkbox"/> 11 months <input type="checkbox"/> 3 months <input type="checkbox"/> 8 months <input type="checkbox"/> 12 months <input type="checkbox"/> 4 months <input type="checkbox"/> 9 months <input type="checkbox"/> More than 12 months <input type="checkbox"/> 5 months		

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HEALTH INFORMATION

	Excellent	Very Good	Good	Fair	Poor	Client doesn't know	Client prefers not to answer
General Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pregnancy Status	<input type="checkbox"/> Yes (Projected Due Date): ____/____/____				<input type="checkbox"/> No	<input type="checkbox"/>	<input type="checkbox"/>

DV INFORMATION

DOMESTIC VIOLENCE VICTIM/SURVIVOR?		<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (If yes, select answer for each question below.)		<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> No		
When did the last experience occur?	<input type="checkbox"/> Within past 3 months <input type="checkbox"/> 3 to 6 months ago <input type="checkbox"/> 6 to 12 months ago <input type="checkbox"/> More than a year ago	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer
Are you currently fleeing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

MONTHLY INCOME INFORMATION

INCOME FROM ANY SOURCE?	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (If yes, select answer for each type below.)	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> No (If no, answer No for all types in HMIS.)	

SOURCES OF INCOME (HUD TABLE)	Yes (specify)	No	Yes (specify)	No
Alimony/Other spousal support	<input type="checkbox"/> \$	<input type="checkbox"/>	Retirement income from social security	<input type="checkbox"/> \$
Child support	<input type="checkbox"/> \$	<input type="checkbox"/>	SSDI	<input type="checkbox"/> \$
Earned income	<input type="checkbox"/> \$	<input type="checkbox"/>	SSI	<input type="checkbox"/> \$
General assistance	<input type="checkbox"/> \$	<input type="checkbox"/>	TANF	<input type="checkbox"/> \$
Other: AK Permanent Fund Dividend (PFD)	<input type="checkbox"/> \$	<input type="checkbox"/>	Unemployment insurance	<input type="checkbox"/> \$
Other: AK Native Corp. Dividend	<input type="checkbox"/> \$	<input type="checkbox"/>	VA non-svc connected disability pension	<input type="checkbox"/> \$
Other (specify):	<input type="checkbox"/> \$	<input type="checkbox"/>	VA svc connected disability compensation	<input type="checkbox"/> \$
Pension/Retirement income	<input type="checkbox"/> \$	<input type="checkbox"/>	Worker's Compensation	<input type="checkbox"/> \$
Private disability insurance	<input type="checkbox"/> \$	<input type="checkbox"/>	Total Monthly Income: \$	

NON-CASH BENEFITS INFORMATION

NON-CASH BENEFITS FROM ANY SOURCE?	<input type="checkbox"/> Client doesn't know
<input type="checkbox"/> Yes (If yes, select answer for each type below.)	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> No (If no, answer No for all types in HMIS.)	

SOURCES OF NON-CASH BENEFITS (HUD TABLE)	Yes	No	Yes	No
TANF Child Care Services	<input type="checkbox"/>	<input type="checkbox"/>	SNAP (Food Stamps)	<input type="checkbox"/>
Special Supp. Nutrition Program for WIC	<input type="checkbox"/>	<input type="checkbox"/>	Other TANF-Funded Services	<input type="checkbox"/>
TANF Transportation Services	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify):	<input type="checkbox"/>

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ADDITIONAL RHY INFORMATION

LAST GRADE COMPLETED					<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Less than Grade 5	<input type="checkbox"/> Grades 9 - 11	<input type="checkbox"/> GED	<input type="checkbox"/> Associate's Degree	<input type="checkbox"/> Graduate Degree		
<input type="checkbox"/> Grades 5 - 6	<input type="checkbox"/> Grade 12 / High School Diploma	<input type="checkbox"/> Some College	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Vocational Certification		
<input type="checkbox"/> Grades 7 - 8	<input type="checkbox"/> School Program does not have grades					

SCHOOL STATUS					<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Attending School Regularly	<input type="checkbox"/> Graduated High School	<input type="checkbox"/> Dropped Out	<input type="checkbox"/> Expelled			
<input type="checkbox"/> Attending School Irregularly	<input type="checkbox"/> Obtained GED	<input type="checkbox"/> Suspended				

EMPLOYMENT STATUS					<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes. Type of Employment:	<input type="checkbox"/> Full-time	<input type="checkbox"/> Part-time	<input type="checkbox"/> Seasonal/sporadic/day labor			
<input type="checkbox"/> No. Why Not Employed:	<input type="checkbox"/> Looking for work	<input type="checkbox"/> Unable to work	<input type="checkbox"/> Not looking for work			

FORMERLY A WARD OF CHILD WELFARE/FOSTER CARE AGENCY?		<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes. Specify number of years (or months, if less than 1 year):			
<input type="checkbox"/> No			

FORMERLY A WARD OF JUVENILE JUSTICE SYSTEM?		<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client prefers not to answer
<input type="checkbox"/> Yes. Specify number of years (or months, if less than 1 year):			
<input type="checkbox"/> No			

FAMILY CRITICAL ISSUES	Yes	No		Yes	No
Unemployment – Family Member	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or Substance Use Disorder – Family Member	<input type="checkbox"/>	<input type="checkbox"/>
Mental Health Disorder – Family Member	<input type="checkbox"/>	<input type="checkbox"/>	Insufficient Income to Support Youth – Family Member	<input type="checkbox"/>	<input type="checkbox"/>
Physical Disability – Family Member	<input type="checkbox"/>	<input type="checkbox"/>	Incarcerated Parent of Youth	<input type="checkbox"/>	<input type="checkbox"/>

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PROJECT EXIT INFORMATION

ENTER DATA AS (EDA) PROJECT	PROJECT EXIT DATE

REASON FOR LEAVING		
<input type="checkbox"/> Advanced to new project	<input type="checkbox"/> Institutional stay	<input type="checkbox"/> Reached max time allow
<input type="checkbox"/> Aged out of project	<input type="checkbox"/> Relocated outside of community	<input type="checkbox"/> Seasonal shelter closed
<input type="checkbox"/> Completed program	<input type="checkbox"/> Left for housing opp. before completing program	<input type="checkbox"/> Unknown/disappeared
<input type="checkbox"/> Criminal activity / violence	<input type="checkbox"/> Lowered Breath Alcohol Content (BrAC)	<input type="checkbox"/> Violation of Probation / Parole
<input type="checkbox"/> Death	<input type="checkbox"/> Needs could not be met	<input type="checkbox"/> Voluntary break in shelter stay
<input type="checkbox"/> Disagreement with rules/person	<input type="checkbox"/> Non-compliance with program	<input type="checkbox"/> Voluntary checkout
<input type="checkbox"/> Housed	<input type="checkbox"/> Non-payment of rent	<input type="checkbox"/> Other (specify):
<input type="checkbox"/> Ineligible for project		

DESTINATION	
Homeless Situation	<input type="checkbox"/> Place not meant for habitation (for example: car, park, abandoned building, bus station, airport, tent) <input type="checkbox"/> Emergency shelter (ES), including hotel or motel paid for with ES voucher, Host Home shelter
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 use treatment facility or detox center
Temporary Housing Situation	<input type="checkbox"/> Transitional housing for homeless persons youth (including homeless youth) <input type="checkbox"/> Residential project/halfway house with no homeless criteria <input type="checkbox"/> Hotel/motel paid for without ES voucher <input type="checkbox"/> Host Home (non-crisis) <input type="checkbox"/> Staying or living with family, temporary tenure <input type="checkbox"/> Staying or living with friends, temporary tenure
Permanent Housing Situation	<input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with housing subsidy (specify): <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Owned by client, no ongoing housing subsidy
Other	<input type="checkbox"/> No exit interview completed <input type="checkbox"/> Other <input type="checkbox"/> Deceased <input type="checkbox"/> Worker unable to determine <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client prefers not to answer

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ADDITIONAL RHY PROJECT EXIT INFORMATION

COMMERCIAL SEXUAL EXPLOITATION / SEX TRAFFICKING

Ever received anything in exchange for sex (e.g., money, food, drugs, shelter)?

- Yes (Answer A, B, and C)
 No

- Client doesn't know
 Client prefers not to answer

A. In the last 3 months? No Yes

- Client doesn't know
 Client prefers not to answer

B. How many times? 1 – 3 4 – 7 8 – 11 12 or more

- Client doesn't know
 Client prefers not to answer

C. Ever made / persuaded / forced to have sex in exchange for something? No Yes (Answer D)

- Client doesn't know
 Client prefers not to answer

D. In the last 3 months? No Yes

- Client doesn't know
 Client prefers not to answer

LABOR EXPLOITATION / TRAFFICKING

Ever afraid to quit or leave work due to threats of violence to yourself, family, or friends?

- Yes (Answer A and B)
 No

- Client doesn't know
 Client prefers not to answer

Ever promised work where work or payment was different than you expected?

- Yes (Answer A and B)
 No

- Client doesn't know
 Client prefers not to answer

A. Felt forced, coerced, pressured, or tricked into continuing the job? No Yes

- Client doesn't know
 Client prefers not to answer

B. In the last 3 months? No Yes

- Client doesn't know
 Client prefers not to answer

PROJECT COMPLETION STATUS

- Completed project
 Client voluntarily left early
 Client was expelled or otherwise involuntarily discharged from project (Answer below.)

- | | | |
|---|--|---|
| If client was expelled or otherwise involuntarily discharged from project, select major reason: | <input type="checkbox"/> Criminal activity/destruction of property/violence
<input type="checkbox"/> Non-compliance with project rules
<input type="checkbox"/> Non-payment of rent/occupancy charge | <input type="checkbox"/> Reached maximum time allowed by project
<input type="checkbox"/> Project terminated
<input type="checkbox"/> Unknown/disappeared |
|---|--|---|

SAFE AND APPROPRIATE EXIT

Yes No Worker does not know

Exit destination safe – as determined by the client

- Client doesn't know
 Client prefers not to answer

Exit destination safe – as determined by the project/caseworker

Client has permanent positive adult connections outside of project

Client has permanent positive peer connections outside of project

Client has permanent positive community connections outside of project

COUNSELING RECEIVED BY CLIENT?

- Yes (Answer A and B)
 No

- Client doesn't know
 Client prefers not to answer

A. Identify type(s) of counseling received Individual Family Group – including peer counseling

- Client doesn't know
 Client prefers not to answer

B. Identify the number of sessions received by exit:

- Client doesn't know
 Client prefers not to answer

Total number of sessions planned in client's treatment or service plan:

A plan is in place to start or continue counseling after exit Yes No