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FY2024 - All Other Projects Exit Assessment (complete this form for ALL Adults and Head of Households)

Client Name: _____ HMIS Client ID#:_____(optional)
Exit Date: _____

Reason for Leaving:

____Completed Program
____Criminal Activity/Violence
____Death
____ Disagreement with Rules
____ Does not meet criteria for program
____ Goal Achieved
____ Goal Not Achieved
____ Left for housing opportunity before completing program
____ Needs could not be met
____ Non-compliance
____ Non payment of rent
____ Reached maximum time allowed
____ Unknown/ Disappeared
____ Other**:** _____

Destinations:

Homeless Situations

_____ Emergency Shelter, incl. hotel/motel paid for w/ES voucher, or RHY funded Host Home shelter
_____ Place not meant for human habitation
_____ Safe Haven (*note: no safe havens exist in the CoC coverage area.)*

Institutional Situations

_____ Foster care home or foster care group home
_____ Hospital or other residential non-psychiatric facility
_____ Jail, prison, or juvenile detention
_____Long-term Care Facility or Nursing Home
_____Psychiatric hospital or other psychiatric facility
_____Substance Abuse Treatment facility or detox center

Temporary Housing Situations:

____ Transitional housing for homeless persons (including homeless youth)
____ Residential project or halfway house with no homeless criteria
____ Hotel or motel paid without emergency voucher
____ Host Home (non-crisis)
____ Staying in family member's room/apartment/house
____ Staying in friend's room/apartment/house

Permanent Housing Situations:

____ Owned by client, no on-going housing subsidy
____ Owned by client, with on-going housing subsidy
____ Rental by client, no ongoing housing subsidy
____ Rental by client, with ongoing subsidy (*If you choose this answer, name the Rental Subsidy Type below*)
- ____ GPD TIP housing subsidy
- ____ VASH housing subsidy
- ____ RRH or equivalent
- ____ HCV voucher (tenant or project based)(not dedicated)
- ____ Public housing unit

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Other Destinations

____No Exit Interview Completed (*Select if contact attempts have been made and client location could not be determined*)
____Deceased
____Other (*Do not select without consulting HMIS staff*): _____
____Client Doesn't Know (*Do not select without consulting HMIS staff*)
____Client Prefers Not to Answer (*Only select if client chooses not to complete assessment*)
____Data Not Collected (*Do not select without consulting HMIS staff*)

Disabling Condition:

Do you have a DISABILITY of long duration? ____Yes ____ No

For each disability, check "LCI" if it is expected to be of long, continued, and indefinite duration, substantially impairs the individual's ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

Disability Type:

__Yes __LCI Alcohol Use Disorder __Yes__LCI BOTH Alcohol & Drug Use Disorder __Yes__LCI Drug Use Disorder
__Yes__LCI Chronic Health Condition __Yes__LCI Developmental _____ HIV/AIDS
__Yes__LCI Mental Health Disorder __Yes__LCI Physical Health

Medical Insurance:

Do you have Health Insurance/ Medical Assistance? ____Yes ____ No

Source of Health Insurance/ Medical Assistance:

_____ 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
_____ Indian Health Care _____ Other

Medicaid ID# _____

Medicaid Insurance Company: ____ Total Care ____ Blue Cross Blue Shield ____ Fidelis
____ United Healthcare ____ Molina Healthcare

Income:

Do you have income? ____Yes ____ No **Total Monthly Income** $_____

Income Source and amount:

$_____ Alimony/ Spousal Support $_____ Child Support
$_____ Earned Income $_____ General Assistance
$_____ Pension/Retirement income from a job $_____ Private Disability Insurance
$_____ Retirement Income from Social Security $_____ Social Security Disability Income (SSDI)
$_____ Social Security Income (SSI) $_____ Temporary Assist for Needy Families TANF
$_____ Unemployment Insurance $_____ VA Non-Service-Connected Disability Pension
$_____ VA Service-Connected Disability Compensation $_____ Worker's Compensation

Non-Cash Benefits:

Do you have Non-Cash Benefits? ____Yes ____ No

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Source of Non-Cash Benefits:

_____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
_____ Special supplemental Nutrition Program for (WIC) (HUD)
_____ TANF Child Care Services (HUD)
_____ TANF Transportation Services (HUD)
_____ Other TANF-Funded Services (HUD); If "Other" Specify: _____