

MSHMIS VASH EXIT

Review Date: _____ Client Location (CoC Code) for HoH: _____ Review Type: Routine. 30 day 60 day 90 day 120 day 180 day Annual

Please Update Any Responses that Have Changed Since Entry/Last Review

Answer this section for all persons in household (use additional sheets for larger families)

Name & Client ID <i>(Answer for All Persons in HH)</i>	Housing Status	General Health Status	Currently Covered by Health Insurance?	(If Client has Health Insurance) Select All Type(s) That Apply
	<input type="checkbox"/> Cat 1-Homeless <input type="checkbox"/> Cat 2-Imminent Risk of losing housing <input type="checkbox"/> Cat 3-Homeless under other Fed Statutes <input type="checkbox"/> Cat 4-Fleeing domestic violence <input type="checkbox"/> At risk of homelessness <input type="checkbox"/> Stably Housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (If Other Specify) _____
	<input type="checkbox"/> Cat 1-Homeless <input type="checkbox"/> Cat 2-Imminent Risk of losing housing <input type="checkbox"/> Cat 3-Homeless under other Fed Statutes <input type="checkbox"/> Cat 4-Fleeing domestic violence <input type="checkbox"/> At risk of homelessness <input type="checkbox"/> Stably Housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (If Other Specify) _____
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	<input type="checkbox"/> Cat 1-Homeless <input type="checkbox"/> Cat 2-Imminent Risk <input type="checkbox"/> Cat 3-Other Fed Statutes <input type="checkbox"/> Cat 4-Fleeing <input type="checkbox"/> At Risk of Homelessness <input type="checkbox"/> Stably Housed <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Excellent <input type="checkbox"/> Very Good <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> MEDICAID <input type="checkbox"/> MEDICARE <input type="checkbox"/> State Children's Health Insurance Program <input type="checkbox"/> Veteran Administration (VA) Medical Services <input type="checkbox"/> Employer Provided Health Insurance <input type="checkbox"/> Health Insurance Obtained through COBRA <input type="checkbox"/> Private Pay Health Insurance <input type="checkbox"/> State Health Insurance for Adults <input type="checkbox"/> Indian Health Services Program <input type="checkbox"/> Other (If Other Specify) _____

Answer this section for all persons in household (use additional sheets for larger families)

Name <i>(Please Answer for All Persons in HH)</i>	Does the client have a disabling condition?	If client has a disabling condition, please answer the following sub-assessment questions:					
		Disability Type <i>(Select all that apply)</i>	Disability Determination	If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?	Documentation of Disability and Severity on File	Currently Receiving Services/Treatment for this disability	Long Term
Person 1 (head of household):	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 2:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 3:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 4:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Physical <input type="checkbox"/> Developmental <input type="checkbox"/> Chronic Health Condition <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Mental Health Problems <input type="checkbox"/> Alcohol Abuse <input type="checkbox"/> Drug Abuse <input type="checkbox"/> Both Alcohol & Drug Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Yes <input type="checkbox"/> No

INCOME & NON-CASH BENEFITS

****Answer for ALL Household Members****

Currently receiving income from any source? Yes No Client doesn't know Client refused

X	Source of Income (Monthly)	Family Member	Amount from Source
	Alimony or Other Spousal Support		\$.00
	Child Support		\$.00
	Earned Income (<i>Employment</i>)		\$.00
	Pension or Retirement Income From a Former Job		\$.00
	Private Disability Insurance		\$.00
	Retirement Income from Social Security		\$.00
	SSDI (<i>Social Security Disability Income</i>)		\$.00
	SSI (<i>Supplemental Security Income</i>)		\$.00
	TANF (<i>Temporary Assistance for Needy Families or FIP</i>) grant		\$.00
	Unemployment Insurance		\$.00
	VA Service-Connected Disability Compensation		\$.00
	VA Non-Service-Connected Disability Pension		\$.00
	Workers Compensation		\$.00
	General Assistance		\$.00
	Other (<i>Including Gifts from Friends and Family</i>)		\$.00
	No Financial Resources		\$.00
	Total Monthly Income Reported		\$.00

(If Other Source), Specify _____ Total Monthly Income (per household member) \$ _____

Currently receiving any non-cash benefits? Yes No Client doesn't know Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (if applicable)
	Supplemental Nutrition Assistance Program (<i>Food Stamps</i>)		\$.00
	Special Supplemental Nutrition Program for WIC		\$.00
	TANF Child Care Services		\$.00
	TANF Transportation Services		\$.00
	Other TANF Funded-Services		\$.00
	Section 8, Public Housing or rental assistance		\$.00
	Other Source		\$.00
	Temporary Rental Assistance		\$.00

(If Other Source), Specify _____

****Answer the following questions for HEAD OF HOUSEHOLD and ADULTS only! (Print additional pages where needed) ****

DOMESTIC VIOLENCE

Domestic Violence Victim/Survivor should be indicated as “**Yes**” if the person has experienced any domestic violence, dating violence, sexual assault, stalking or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has taken place **within the individual’s or family’s primary nighttime residence**.

Domestic Violence Victim/Survivor? Yes No Client doesn’t know Client refused

(If yes) When Experience Occurred

Within the past three months Three to six months ago (excluding six months exactly) Six months to one year ago (excluding one year exactly) One year ago or more Client doesn’t know Client refused

Currently fleeing should be indicated as “**Yes**” if the Person is fleeing, or is attempting to flee, the domestic violence situation **or** is afraid to return to their primary nighttime residence.

(If yes) Are you currently fleeing? Yes No Client doesn’t know Client refused

Overview of domestic violence: _____

EMPLOYMENT STATUS

Employed: Yes No Client Doesn’t Know Client Refused

Type of Employment: Full-time Part-time Seasonal/sporadic (including day labor)

If NO, Why not employed: Looking for Work Unable to work Not looking for work

RESIDENTIAL MOVE-IN DATE ****Answer the following questions for ALL Household Members****

Date of Move-In _____ ****IMPORTANT: Not same as the Move-In date listed on the VA HOMES System**

CONTACT INFORMATION

Client’s Cell Phone Number: _____

Emergency Contact’s Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second_Phone Number: _____

Contact’s E-mail Address: _____

Contact’s Street Address: _____

Contact’s City: _____ State: _____ Zip Code: _____

Emergency Contact’s Name: _____

Contact Type (Relationship to Client): _____

Phone Number: _____

Second_Phone Number: _____

Contact’s E-mail Address: _____

Contact’s Street Address: _____

Contact’s City: _____ State: _____ Zip Code: _____