

MSHMIS Youth Exit Form

Exit Date: _____

Client ID#: _____

Case Manager: _____

First Name: _____

Middle Name: _____

Last Name: _____

Reason for Leaving

- | | | |
|--|---|---|
| <input type="checkbox"/> Completed Program | <input type="checkbox"/> Left for Housing Opportunity before completing program | <input type="checkbox"/> Other |
| <input type="checkbox"/> Criminal activity/violence | <input type="checkbox"/> Needs could not be met | <input type="checkbox"/> Reached maximum time allowed |
| <input type="checkbox"/> Death | <input type="checkbox"/> Non-compliance with program | <input type="checkbox"/> Time allowed expired |
| <input type="checkbox"/> Disagreement with rules/persons | <input type="checkbox"/> Non-payment of rent | <input type="checkbox"/> Unknown/Disappeared |

(If Other), Specify _____

Destination

- | | | |
|--|---|--|
| <input type="checkbox"/> Deceased | <input type="checkbox"/> Owned by client, with ongoing housing subsidy | <input type="checkbox"/> Safe Haven |
| <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher | <input type="checkbox"/> Permanent supportive housing for formerly homeless persons (e.g. SHP S+C, or SRO Mod Rehab) | <input type="checkbox"/> Staying or living with family, permanent tenure |
| <input type="checkbox"/> Foster care home or foster care group home | <input type="checkbox"/> Place not meant for human habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) | <input type="checkbox"/> Staying or living with family, temporary tenure (e.g. room, apartment or house) |
| <input type="checkbox"/> Hospital or other residential non-psychiatric medical facility | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility | <input type="checkbox"/> Staying or living with friends, permanent tenure |
| <input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher | <input type="checkbox"/> Rental by client, no ongoing housing subsidy | <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g. room, apartment, or house) |
| <input type="checkbox"/> Jail, prison or juvenile detention facility | <input type="checkbox"/> Rental by client, with VASH subsidy | <input type="checkbox"/> Substance abuse treatment facility or detox center |
| <input type="checkbox"/> Long-term care facility or nursing home | <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy | <input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH | <input type="checkbox"/> Residential project or halfway house with no homeless criteria | <input type="checkbox"/> Client doesn't know |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy | | <input type="checkbox"/> Client refused |
| | | <input type="checkbox"/> No exit interview completed |

(If Other), Specify _____

DISCHARGE STATUS

Program Completion Status

- Completed project
 Youth was expelled or otherwise involuntarily discharged from project
- Youth voluntarily left early

If left early, select the major reason

- Left for other opportunities – Independent Living
 Left for other opportunities – Other
- Left for other opportunities – Education
 Needs could not be met by project
- Left for other opportunities – Military

If expelled or involuntarily discharged, select the major reason

- Criminal activity/destruction of property/violence
 Reached maximum time allowed by project
- Non-compliance with project rules
 Project terminated
- Non-payment of rent/occupancy change
 Unknown/disappeared

HYR Service Plan Completion Status

- Fully
 Not at All
- Partially
 N/A

Family Reunification Achieved

- Yes
 Client doesn't know
- No
 Client refused

Exit Services Provided (Aftercare Information)

Service	Yes	No	Client Refused
A written transitional, aftercare or follow-up plan or agreement			
Advice about and/or referral to appropriate mainstream assistance programs			
Placement in appropriate, permanent, stable housing (not a shelter)			
The youth must be transported or accompanied to a temporary shelter			
Exit counseling			
A course of further follow-up treatment or services			
A follow-up meeting or series of staff/youth meeting or contacts has been scheduled			
A package of such things as maps, information about shelters and other resources			
Other			

UPDATE INFORMATION (If applicable)

Does the client have a disabling condition?

- Yes
 No

- Client doesn't know
 Client refused

Disability Sub-assessment

Disability Type	Disability Determination				If Yes, to be of long-continued and indefinite duration and substantially impairs ability to live independently?				Documentation of disability and severity on File? Y/N	Currently receiving services/treatment for this disability			
	Yes	No	Client doesn't know	Client Refused	Yes	No	Client doesn't know	Client Refused		Yes	No	Client doesn't know	Client Refused
Physical													
Developmental													
Chronic Health Condition													
HIV/AIDS													
Mental Health Problem													
Alcohol Abuse													
Drug Abuse													
Both Alcohol & Drug Abuse													

Notes on Disability: _____

General Health Status

- Excellent
 Very Good
 Good

- Fair
 Poor

- Client doesn't know
 Client refused

Dental Health Status

- Excellent
 Very Good
 Good

- Fair
 Poor

- Client doesn't know
 Client refused

Mental Health Status

- Excellent
 Very Good
 Good

- Fair
 Poor

- Client doesn't know
 Client refused

Pregnant?

- Yes
- No

- Client doesn't know
- Client refused

If Yes, Projected Birth Date: _____

Covered by Health Insurance?

- Yes
- No

- Client doesn't know
- Client refused

HEALTH INSURANCE sub-assessment

Insurance Type	Yes	No
MEDICAID		
MEDICARE		
State Children's Health Insurance Program		
Veteran Administration (VA) Medical Services		
Employer-Provided Health Insurance		
Health Insurance obtained through COBRA		
Private Pay Health Insurance		
State Health Insurance for Adults		
Indian Health Services Program		
Other (Please Specify: _____)		

EMPLOYMENT INFORMATION

Employed?

- Yes
- No

- Client doesn't know
- Client refused

If Yes, 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

INCOME & NON-CASH BENEFITS

Currently receiving income from any source? *(Youth Income Only – Do not include parents' income)*

- 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
	General Assistance		\$.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 grant)</i>		\$.00
	Unemployment Insurance		\$.00
	VA Service-Connected Disability Compensation		\$.00
	VA Non-Service-Connected Disability Pension		\$.00
	Workers Compensation		\$.00
	Other <i>(Including Gifts from Friends and Family)</i>		\$.00
	No Financial Resources		N/A

(If Other Source) Specify: _____

Total Monthly Income \$ _____

Currently receiving any non-cash benefits? *(Youth Benefits Only – Do not include parents' 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
	Temporary Rental Assistance		\$.00
	Other Source – Specify: _____		\$.00

REMEMBER TO COMPLETE APPROPRIATE MATRIX

CONTACT INFORMATION

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

Contact Address: _____

Contact Phone: _____

Contact Email: _____

Contact Type: _____

Contact Name: _____

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