

# MSHMIS Youth Street Outreach 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"/> Residential project or halfway house with no homeless criteria                    |
| <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher | <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons   | <input type="checkbox"/> Safe Haven  |
| <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, permanent tenure                                   |
| <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 family, temporary tenure (e.g. room, apartment or house)   |
| <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, permanent tenure                                  |
| <input type="checkbox"/> Jail, prison or juvenile detention facility   | <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy   | <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g. room, apartment, or house) |
| <input type="checkbox"/> Long-term care facility or nursing home   | <input type="checkbox"/> Rental by client, with VASH subsidy  | <input type="checkbox"/> Substance abuse treatment facility or detox center                                |
| <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH                                     | <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 TH                                     | <input type="checkbox"/> Rental by client, with other ongoing housing subsidy   | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Owned by client, no ongoing housing subsidy   |   | <input type="checkbox"/> Client doesn't know   |
|  |   | <input type="checkbox"/> Client refused  |
|  |   | <input type="checkbox"/> No exit interview completed   |

(If Other), Specify \_\_\_\_\_

## COMMERCIAL SEXUAL EXPLOITATION/SEX TRAFFICKING

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

*\*This includes any form of sexual relations*

- Yes
- No

- Client doesn't know
- Client refused

**If Yes, In the last three months?**

- Yes
- No

- Client doesn't know
- Client refused

**If Yes, How many times?**

- 1-3
- 4-7
- 8-11
- 12 or more

- Client doesn't know
- Client refused

**If Yes, Ever made/persuaded/forced to have sex in exchange for something**

*\*Did someone ever make or persuade you to have sex with anyone else in exchange for something such as money, food, drugs or shelter?*

- Yes
- No

- Client doesn't know
- Client refused

**If Yes, In the last three months?**

- Yes
- No

- Client doesn't know
- Client refused

## LABOR EXPLOITATION/TRAFFICKING

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

- Yes
- No

- Client doesn't know
- Client refused

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

- Yes
- No

- Client doesn't know
- Client refused

**If Yes (to either of the above), did you feel forced, coerced, pressured or tricked into continuing this job?**

- Yes
- No

- Client doesn't know
- Client refused

**If Yes (to either of the above), have you had any jobs like these in the last 3 months?**

- Yes
- No

- Client doesn't know
- Client refused

## UPDATE INFORMATION (If applicable)

Does the client have a disabling condition?

- Yes  
 No

- Client doesn't know  
 Client refused

Disability Type	Disability Determination				If Yes, to be of long-continued and indefinite duration and substantially impairs ability to live independently?			
	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: \_\_\_\_\_

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

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: _____)		

# Providers MUST record EACH contact made with street outreach clients.

Please see the *HMIS Data Collection –Street Outreach Supplemental Form* and *2017 HUD Data Standards* for more information.

## CONTACT INFORMATION

Contact Type: \_\_\_\_\_  
 Contact Name: \_\_\_\_\_  
 Contact Address: \_\_\_\_\_  
 Contact Phone: \_\_\_\_\_  
 Contact Email: \_\_\_\_\_

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 Contact Name: \_\_\_\_\_  
 Contact Address: \_\_\_\_\_  
 Contact Phone: \_\_\_\_\_  
 Contact Email: \_\_\_\_\_

## FUNDER SPECIFIC QUESTIONS

### ESG ONLY

(Youth) Currently receiving income from any source?

- Yes  
 No

- Client doesn't know  
 Client refused

X	Source of Income (Monthly)	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 Insurance</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
	<b>No Financial Resources</b>	<b>N/A</b>

(If Other Source) Specify: \_\_\_\_\_

Total Monthly Income \$ \_\_\_\_\_

**Currently receiving any non-cash benefits?**

- Yes
- No

- Client doesn't know
- Client refused

X	Source of Non-Cash Benefit (Monthly)	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
	Other Source – <b>Specify:</b> _____	\$ .00

*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**

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