

MSHMIS Exit Form

Applicable to all Project Types **Except** Youth (HHS & RHY) and VASH

Exit Date: _____

Staff/Case Manager: _____

HOUSEHOLD INFORMATION

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

Name	Reason for Leaving	Destination	
<p> <input type="checkbox"/> Completed Program <input type="checkbox"/> Criminal activity/violence <input type="checkbox"/> Death <input type="checkbox"/> Disagreement with rules/persons <input type="checkbox"/> Left for Housing Opportunity before completing program <input type="checkbox"/> Needs could not be met <input type="checkbox"/> Non-compliance with program <input type="checkbox"/> Non-payment of rent <input type="checkbox"/> Other <input type="checkbox"/> Reached maximum time allowed <input type="checkbox"/> Time allowed expired <input type="checkbox"/> Unknown/Disappeared <i>(If Other),</i> Specify _____ </p>	<p> <input type="checkbox"/> Deceased <input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher <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"/> Hotel or motel paid for without emergency shelter voucher <input type="checkbox"/> Jail, prison or juvenile detention facility <input type="checkbox"/> Long-term care facility or nursing home <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA PH <input type="checkbox"/> Moved from one HOPWA funded project to HOPWA TH <input type="checkbox"/> Other <input type="checkbox"/> Owned by client, no ongoing housing subsidy <input type="checkbox"/> Owned by client, with ongoing housing subsidy <input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons <input type="checkbox"/> Place not meant for human habitation (e.g. a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside <i>(If Other),</i> Specify _____ </p>	<p> <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Client refused <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Safe Haven <input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) <input type="checkbox"/> No exit interview completed </p>	<p> <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Client refused <input type="checkbox"/> Rental by client, with RRH or equivalent subsidy <input type="checkbox"/> Rental by client, no ongoing housing subsidy <input type="checkbox"/> Rental by client, with other ongoing housing subsidy <input type="checkbox"/> Rental by client, with VASH housing subsidy <input type="checkbox"/> Rental by client, with GPD TIP housing subsidy <input type="checkbox"/> Residential project or halfway house with no homeless criteria <input type="checkbox"/> Safe Haven <input type="checkbox"/> Staying or living with family, permanent tenure <input type="checkbox"/> Staying or living with family, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Staying or living with friends, permanent tenure <input type="checkbox"/> Staying or living with friends, temporary tenure (e.g., room, apartment, or house) <input type="checkbox"/> Substance abuse treatment facility or detox center <input type="checkbox"/> Transitional Housing for homeless persons (including homeless youth) <input type="checkbox"/> No exit interview completed </p>

HOUSEHOLD INFORMATION continued...

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

Name <i>(Answer for All Persons in HH)</i>	If HARA, Answer the following:	Housing Assessment at Exit <i>(Required for Prevention)</i>		
		Housing Assessment at Exit	<i>*(If able to maintain the housing they had at project entry)</i> Subsidy Information	<i>*(If moved to new housing unit)</i> Subsidy Information
	<input type="checkbox"/> Client Relocated to Affordable Housing Preventing Homelessness <input type="checkbox"/> Literally Homeless (#1 on intake Housing Status) – Client diverted to Housing w/out Sheltering <input type="checkbox"/> Prevention (#2 on intake Housing Status) – Client sustained housing w/out Sheltering <input type="checkbox"/> Shelter/Hotel was required while waiting for Housing <input type="checkbox"/> Client failed to Follow-Up/Client was dropped from the program	<input type="checkbox"/> Able to maintain the housing they had at project entry <input type="checkbox"/> Moved to a new housing unit <input type="checkbox"/> Moved in with family/friends on a temporary basis <input type="checkbox"/> Moved in with family/friends on a permanent basis <input type="checkbox"/> Moved to a transitional or temporary housing facility or program <input type="checkbox"/> Client became homeless – moving to a shelter or other place unfit for human habitation <input type="checkbox"/> Client went to jail/prison <input type="checkbox"/> Client died <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Without a subsidy <input type="checkbox"/> With the subsidy they had at project entry <input type="checkbox"/> With an on-going subsidy acquired since project entry <input type="checkbox"/> Only with financial assistance other than subsidy	<input type="checkbox"/> With an ongoing subsidy <input type="checkbox"/> Without an ongoing subsidy
	<input type="checkbox"/> Client Relocated to Affordable Housing Preventing Homelessness <input type="checkbox"/> Literally Homeless (#1 on intake Housing Status) – Client diverted to Housing w/out Sheltering <input type="checkbox"/> Prevention (#2 on intake Housing Status) – Client sustained housing w/out Sheltering <input type="checkbox"/> Shelter/Hotel was required while waiting for Housing <input type="checkbox"/> Client failed to Follow-Up/Client was dropped from the program	<input type="checkbox"/> Able to maintain the housing they had at project entry <input type="checkbox"/> Moved to a new housing unit <input type="checkbox"/> Moved in with family/friends on a temporary basis <input type="checkbox"/> Moved in with family/friends on a permanent basis <input type="checkbox"/> Moved to a transitional or temporary housing facility or program <input type="checkbox"/> Client became homeless – moving to a shelter or other place unfit for human habitation <input type="checkbox"/> Client went to jail/prison <input type="checkbox"/> Client died <input type="checkbox"/> Client doesn't know <input type="checkbox"/> Client refused	<input type="checkbox"/> Without a subsidy <input type="checkbox"/> With the subsidy they had at project entry <input type="checkbox"/> With an on-going subsidy acquired since project entry <input type="checkbox"/> Only with financial assistance other than subsidy	<input type="checkbox"/> With an ongoing subsidy <input type="checkbox"/> Without an ongoing subsidy

HOUSEHOLD INFORMATION continued...

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

Name <i>(Answer for All Persons in HH)</i>	Currently Covered by Health Insurance	If Client has health insurance, select all that apply:	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?	Long Term (Yes/No)
	<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 <i>If Other, Specify:</i> _____	<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"/> 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 <i>If Other, Specify:</i> _____	<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

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

INCOME & NON-CASH BENEFITS

Currently receiving income from any source?

- Yes Client doesn't know
 No 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 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>) Specify: _____		\$.00
	No Financial Resources		N/A

Total Monthly Income \$ _____ (Per Household Member)

Currently receiving any non-cash benefits?

- Yes Client doesn't know
 No Client refused

X	Source of Non-Cash Benefit (Monthly)	Family Member	Amount (If applicable)
	Supplemental Nutrition Assistance Program (SNAP) (Previously known as Food Stamps)		\$.00
	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)		\$.00
	TANF Child Care Services		\$.00
	TANF Transportation Services		\$.00
	Other TANF Funded Services		\$.00
	Other Source – Specify: _____		\$.00

Assessment Disposition (Required for Coordinated Assessment – HEAD OF HOUSEHOLD Only)

- Referred to emergency shelter/safe haven
- Referred to transitional housing
- Referred to rapid re-housing
- Referred to permanent supportive housing
- Referred to homeless outreach
- Referred to street outreach
- Referred to other continuum project type
- Referred to a homelessness diversion program
- Unable to refer/accept within continuum; ineligible for continuum projects
- Unable to refer/accept within continuum; continuum services unavailable
- Referred to other community project (non-continuum)
- Applicant denied referral/acceptance
- Applicant terminated assessment prior to completion
- Other/specify

CONTACT INFORMATION

To obtain the client's emergency contact information, intake staff should ask the client, "If you wish to be contacted regarding benefits that you may be eligible for or in the case of an emergency, we will need your best Contact Information. Some services are very time limited so please be as accurate as possible and include how we might reach you even as your circumstances are changing."

Client's Cell Phone Number _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ **City** _____ **State** _____

Contact's Zip Code _____

Emergency Contact's Name _____

Contact Type (Relationship to Client) _____

Phone Number _____

Second Phone Number _____

Email Address _____

Contact's Address: Street _____ City _____ State _____

Contact's Zip Code _____

CONTACTS & ENGAGEMENT

(REQUIRED FOR ALL STREET OUTREACH AND NBN SHELTERS)

Street Outreach Projects and **Emergency Shelters** using the **Night-by-Night Method of Tracking** MUST record the date and if the client is staying on the streets, ES or SH of **EACH CONTACT** made with clients including the **'Date of Engagement'**.

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

FUNDER SPECIFIC QUESTIONS

DHS-ESP ONLY

Only answer questions in this box if your agency receives ESP-TANF funding from DHS or through The Salvation Army (Required for ALL clients)

Referred from HARA? Yes No

→ If No, Date Client Referred to HARA: ___ / ___ / _____

TANF Eligible Family? Yes No

ESP Billing Status:

Bill ESP for this Client

Do Not Bill ESP for this Client

Health Care for Homeless Vets Qualified

Not Applicable

in Household _____

Adults _____

Children _____

DHS ESP Motel Funding Request

Motel Programs HoH ONLY

(One line for each Funding Request)

Total Hotel/ Motel Amount	Coverage Start Date	Coverage End Date	ESP Hotel/Motel Vendor Name	County of ESP Hotel/Motel:
\$.				
\$.				