

MSHMIS SSVF Exit

Project Exit Date: _____

Staff/Case Manager: _____

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

HOUSEHOLD INFORMATION

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

Name & Client ID	Reason for Leaving	Destination		
	<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 _____	<input type="checkbox"/> Deceased <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"/> 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) <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Rental by client, with RRH or equivalent 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"/> Other, Specify _____	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client refused <input type="checkbox"/> No exit interview completed
	<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 _____	<input type="checkbox"/> Deceased <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"/> 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) <input type="checkbox"/> Psychiatric hospital or other psychiatric facility <input type="checkbox"/> Rental by client, no ongoing housing subsidy	<input type="checkbox"/> Rental by client, with RRH or equivalent 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"/> Other, Specify _____	<input type="checkbox"/> Client Doesn't Know <input type="checkbox"/> Client refused <input type="checkbox"/> No exit interview completed

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>	Does the client have a disabling condition?	Disability Type <i>(Select all that apply)</i>	<i>If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?</i>	Currently Covered by Health Insurance?	<i>(If Client has Health Insurance) Select All Type(s) That Apply</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 Problem <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"/> 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"/> 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 Problem <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"/> 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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CONNECTION WITH SOAR

Yes No Client Doesn't Know Client Refused

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
	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)

Percentage of AMI: Less than 30% 30% to 50% Greater than 50%

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 (SNAP) (<i>previous known as Food Stamps</i>)		\$.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

LAST GRADE COMPLETED for HEAD OF HOUSEHOLD and ADULTS (18+) only

Highest Level of Education Attained: Less than Grade 5 Grades 5-6 Grades 7-8 Grades 9-11 Grade 12/High school diploma GED Some College
 School program does not have grade levels Associate's Degree Bachelor's Degree Graduate Degree Vocational Certification
 Client doesn't know Client refused

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 _____

HOUSING MOVE-IN DATE

****Answer for the Head of Household****

For RAPID REHOUSING only!

*This question differentiates between clients who are awaiting placement and those who have moved into any type of permanent housing, regardless of funding source or whether the project is providing rental assistance. The Housing Move-In Date MUST be entered via an **Interim Assessment** with a timestamp that occurs after the Project Start and before the Project Exit. If client is **not** in housing leave this question blank.*

Housing Move-In Date: ____/____/____