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

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

Name & Client ID *(Answer for All Persons in HH)*	**Does the client have a disabling condition?**	*Disability Type (Select all that apply)*	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**
	☐ 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	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ 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 (If Other Specify)________________
	☐ 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	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ 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 (If Other Specify)________________
	☐ 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	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ 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 (If Other Specify)________________
	☐ 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	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ 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 (If Other Specify)________________

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 *(Employment)*		$ .00
	General Assistance		$ .00
	Pension or Retirement Income from a Former Job		$ .00
	Private Disability Insurance		$ .00
	Retirement Income from Social Security		$ .00
	SSDI *(Social Security Disability Insurance)*		$ .00
	SSI *(Supplemental Security Income)*		$ .00
	TANF *(Temporary Assistance for Needy Families or FIP grant)*		$ .00
	Unemployment Insurance		$ .00
	VA Service-Connected Disability Compensation		$ .00
	VA Non-Service-Connected Disability Pension		$ .00
	Workers Compensation		$ .00
	Other *(Including Gifts from Friends and Family)* **Specify**:_____		$ .00
	No Financial Resources		**N/A**

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 (SNAP) *(previous 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

ADULT CARE HOME **for HEAD OF HOUSEHOLD and ADULTS (18+) only!**

Has Client Lived in an Adult Care Home in 2012? ☐ No ☐ Yes ☐ Client doesn't know ☐ Client refused

(If Yes) Adult Care Home Client Lived In Most Recently: _____

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 PH 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: _____/_____/_____