NC HMIS HOPWA Exit Form 2017

(SSO, Homeless Prevention, Rapid Rehousing, PH, TH)

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	
	□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 □ Client Doesn't Know □ 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 □ Other □ 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 (*If Other*), Specify_______________________________	□ Psychiatric hospital or other psychiatric facility □ Client refused □ Rental by client, no ongoing housing subsidy □ Rental by client with RRH or equivalent subsidy □ Rental by client, with other ongoing housing subsidy □ Rental by client, with VASH 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) □ 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 □ Client Doesn't Know □ 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 □ Other □ 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 (*If Other*), Specify_______________________________	□ Psychiatric hospital or other psychiatric facility □ Client refused □ Rental by client, no ongoing housing subsidy □ Rental by client with RRH or equivalent subsidy □ Rental by client, with other ongoing housing subsidy □ Rental by client, with VASH 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) □ No exit interview completed

<table>
<tr><th rowspan="2">Name
(Answer for All Persons in HH)</th><th colspan="3">Housing Assessment at Exit
(Required for Prevention)</th><th rowspan="2">Residential Move In Date
(RRH Only)</th></tr>
<tr><th>Housing Assessment at Exit</th><th>*(If able to maintain the housing they had at project entry)
Subsidy Information</th><th>*(If moved to new housing unit)
Subsidy Information</th></tr>
<tr><td></td><td>□ Able to maintain the housing they had at project entry
□ Moved to a new housing unit
□ Moved in with family/friends on a temporary basis
□ Moved in with family/friends on a permanent basis
□ Moved to a transitional or temporary housing facility or program
□ Client became homeless – moving to a shelter or other place unfit for human habitation
□ Client went to jail/prison
□ Client died
□ Client doesn’t know
□ Client refused</td><td>□ Without a subsidy
□ With the subsidy they had at project entry
□ With an on-going subsidy acquired since project entry
□ Only with financial assistance other than subsidy</td><td>□ With an ongoing subsidy
□ Without an ongoing subsidy</td><td>__________</td></tr>
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</table>

HOUSEHOLD INFORMATION
Required Data Entry Fields for All Clients
Answer this section for all persons in household (use additional sheets for larger families)

Name *(Answer for All Persons in HH)*	**Does the client have a disabling condition?**	**If client has a disabling condition, please answer the following sub-assessment questions:**			
		Disability Type (Select all that apply)	*Disability Determination*	*If Yes, to be long-continued and indefinite duration and substantially impairs ability to live independently?*	*Long Term (Yes/ No)*
	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No
	☐ Yes ☐ No ☐ Client doesn't Know ☐ Client refused	☐ Physical ☐ Developmental ☐ Chronic Health Condition ☐ HIV/AIDS ☐ Mental Health Problems ☐ Alcohol Abuse ☐ Drug Abuse ☐ Both Alcohol & Drug Abuse	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No

Notes on Disability: ____

HOUSEHOLD INFORMATION continued… **Answer this section for all persons in the household (use additional sheets for larger families)**		
Name *(Answer for All Persons in HH)*	**Currently Covered by Health Insurance?**	***(If Client has Health Insurance)*** **Select All Type(s) That Apply**
	☐ 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 (Please Specify: ____)
	☐ 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 (Please Specify: ____)
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		☐ Other (Please Specify: ____)

HOUSEHOLD INFORMATION continued…

Answer this section for all persons in the household with HIV/AIDS (use additional sheets for larger families)

Name *(Answer for All Persons in HH with HIV/AIDS)*	**Receiving Public HIV/AIDS Medical Assistance?**	**If No, Reason**	**Receiving AIDS Drug Assistance Program (ADAP)?**	**If No, Reason**
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused	☐ Applied; decision pending ☐ Applied; client not eligible ☐ Client did not apply ☐ Insurance type N/A for this client ☐ Client doesn't know ☐ Client refused
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HOUSEHOLD INFORMATION continued…

Answer this section for all persons in the household with HIV/AIDS (use additional sheets for larger families)

Name *(Answer for All Persons in HH with HIV/AIDS)*	**T-cell (CD4) Count Available?**	**How was the data obtained?**	**Viral Load Available?**	**How was the data obtained?**
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected *(If Yes)* **T-cell Count (0-1500)** _________________	☐ Medical report ☐ Client report ☐ Other	☐ Not available ☐ Available ☐ Undetectable ☐ Client refused ☐ Data not collected *(If Available)* **Viral Load (0-999999)** _________________	☐ Medical report ☐ Client report ☐ Other
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected *(If Yes)* **T-cell Count (0-1500)** _________________	☐ Medical report ☐ Client report ☐ Other	☐ Not available ☐ Available ☐ Undetectable ☐ Client refused ☐ Data not collected *(If Available)* **Viral Load (0-999999)** _________________	☐ Medical report ☐ Client report ☐ Other
	☐ Yes ☐ No ☐ Client doesn't know ☐ Client refused ☐ Data not collected *(If Yes)* **T-cell Count (0-1500)** _________________	☐ Medical report ☐ Client report ☐ Other	☐ Not available ☐ Available ☐ Undetectable ☐ Client refused ☐ Data not collected *(If Available)* **Viral Load (0-999999)** _________________	☐ Medical report ☐ Client report ☐ Other

Housing Status

- ☐ Category 1 - Homeless
- ☐ Category 2 – At imminent risk of losing housing
- ☐ Category 3 – Homeless only under other federal statues
- ☐ Category 4 – Fleeing domestic violence
- ☐ At-risk of homelessness
- ☐ Stably Housed
- ☐ Client doesn't know
- ☐ Client refused

Client Location *(CoC Code):* ________________________ **(Answer for Head of Household Only)**

****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
- ☐ 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 *(Food Stamps)*		$ .00
	Special Supplemental Nutrition Program for WIC		$ .00
	TANF Child Care Services		$ .00
	TANF Transportation Services		$ .00
	Other TANF Funded Services		$ .00
	Other Source – **Specify**: _____________________________		$ .00