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	
	□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, with RRH or equivalent subsidy □ Rental by client, no ongoing housing subsidy □ Rental by client, with other ongoing housing 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) □ 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, with RRH or equivalent subsidy □ Rental by client, no ongoing housing subsidy □ Rental by client, with other ongoing housing 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) □ No exit interview completed

HOUSEHOLD INFORMATION continued…
Answer this section for all persons in household (use additional sheets for larger families)

Name *(Answer for All Persons in HH)*	**Assessment Disposition** *(Required for Coordinated Assessment ONLY)* **Head of Household ONLY**	**Housing Assessment at Exit** *(Required for Prevention)*		
	Assessment Disposition	**Housing Assessment at Exit**	**(If able to maintain the housing they had at project entry)* **Subsidy Information**	**(If moved to new housing unit)* **Subsidy Information**
	□ 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 _____	□ 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	□ 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	□ With an ongoing subsidy □ Without an ongoing subsidy
	N/A	□ 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	□ 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	□ With an ongoing subsidy □ Without an ongoing subsidy

HOUSEHOLD INFORMATION continued…

Answer this section for all persons in 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 that apply:**	**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	☐ 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 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	☐ 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 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

****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 (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

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:
$.				
$.				