

AKHMIS Exit SSVF All Projects

On the Exit Assessment, the health insurance coverage, disability information, monthly income, and / or non-cash benefits only need to be answered if there has been a change in the client's / household's information since Project Start Date or the most recent Interim Review / Annual Assessment.

Date: ____ / ____ / ____

Exit Completed By: _____

Client Name / Household: _____

Reason for Leaving

- | | |
|---|--|
| <input type="checkbox"/> Advanced to new project | <input type="checkbox"/> Aged out of project |
| <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"/> Housed | <input type="checkbox"/> Ineligible for project |
| <input type="checkbox"/> Left for housing before completing program | <input type="checkbox"/> Lowered BrAC |
| <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"/> Relocated outside of community |
| <input type="checkbox"/> Unknown / disappeared | <input type="checkbox"/> Violation of probation / parole |
| <input type="checkbox"/> Voluntary break in shelter stay | <input type="checkbox"/> Voluntary checkout |

Destination

- | | |
|--|---|
| <input type="checkbox"/> Deceased | <input type="checkbox"/> Emergency shelter, including hotel paid for with 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 paid for without 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 HOPWA-funded to HOPWA TH | <input type="checkbox"/> Owned by client, no housing subsidy |
| <input type="checkbox"/> Owned by client, ongoing housing subsidy | <input type="checkbox"/> Permanent housing (not RRH) for homeless persons |
| <input type="checkbox"/> Place not meant for habitation | <input type="checkbox"/> Psychiatric hospital or other psychiatric facility |
| <input type="checkbox"/> Rental by client, no ongoing subsidy | <input type="checkbox"/> Rental by client, VASH subsidy |
| <input type="checkbox"/> Rental by client, RRH or equivalent subsidy | <input type="checkbox"/> Rental by client, GPD TIP subsidy |
| <input type="checkbox"/> Rental by client, other housing subsidy | <input type="checkbox"/> Residential project / halfway house, no homeless criteria |
| <input type="checkbox"/> Staying with family, permanent tenure | <input type="checkbox"/> Staying with family, temporary tenure |
| <input type="checkbox"/> Staying with friends, permanent tenure | <input type="checkbox"/> Staying with friends, temporary tenure |
| <input type="checkbox"/> Substance abuse treatment / detox center | <input type="checkbox"/> Transitional housing for homeless persons |
| <input type="checkbox"/> Other | <input type="checkbox"/> No exit interview completed |

Covered by Health Insurance?

____ Yes (if yes, select specific type(s))

____ No

- | | |
|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Medicare |
| <input type="checkbox"/> State Children's Health Insurance Program | <input type="checkbox"/> Veteran's Administration 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 |

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Do you have a Disabling Condition? Yes No

If Yes, indicate the specific type(s) and answer the additional questions

Disability Type	Yes or No	Expected to be of long-continued and indefinite duration and substantially impair the individual's ability to live independently?	Condition going to be long-term?
Alcohol Abuse			
Both Alcohol and Drug Abuse			
Chronic Health Condition			
Developmental			
Drug Abuse			
HIV / AIDS			
Mental Health Problem			
Physical			

Rapid Rehousing Component ONLY

Housing Move-In Date: ___/___/_____

Do you have any monthly income? Yes No

If Yes, what is the total monthly amount? \$ _____

If Yes, select the specific sources and the monthly amount of each source

Alimony or other spousal support	\$
TANF	\$
Child support	\$
Earned income	\$
General assistance	\$
Pension or retirement income from another job	\$
Private disability insurance	\$
SSDI	\$
SSI	\$
Retirement income from social security	\$
Unemployment insurance	\$
VA service connected disability compensation	\$

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VA non-service connected disability pension	\$
Worker's compensation	\$
Other	\$

Do you receive any non-cash benefits?

- TANF Child Care Services
- Other TANF-Funded Services
- SNAP (Food Stamps)

Yes (if yes, select specific type(s)) No

- TANF Transportation Services
- Special Supplemental Nutrition Program for WIC
- Other Source

Connection with SOAR? Yes No