

## 6.0 Project Exit Assessment – RRH, OPH, PSH

This form should be used for every client exiting Rapid Re-Housing, Other Permanent Housing & Permanent Supportive Housing Projects. (children pages 1-2; all adults pages 1-4; heads of household pages 1-5)

### ANSWER FOR ALL HOUSEHOLD MEMBERS

DATE OF PROJECT EXIT									
		/			/				
Month			Day			Year			

CLIENT NAME

HMIS CLIENT ID - For HMIS Users only							

REASON FOR LEAVING – Why is the client leaving this project? Required for NC-502 Durham; recommended for NC-503 Balance of State and NC-513 Orange	
<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 opp. before completing program
<input type="checkbox"/>	Needs could not be met
<input type="checkbox"/>	Does not or no longer qualifies for program
<input type="checkbox"/>	Non-compliance with program
<input type="checkbox"/>	Non-payment of rent
<input type="checkbox"/>	Other (specify):
<input type="checkbox"/>	Reached maximum time allowed
<input type="checkbox"/>	Unknown/Disappeared

DESTINATION - Where will the client stay/sleep immediately after leaving this project?	
<b>Homeless</b>	<input type="checkbox"/> Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)
	<input type="checkbox"/> Emergency shelter, including hotel or motel paid for <i>with</i> emergency shelter voucher, or RHY-funded Host Home shelter
<b>Institutional</b>	<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"/> Jail, prison, or juvenile detention facility
	<input type="checkbox"/> Long-term care facility or nursing home
	<input type="checkbox"/> Psychiatric hospital or other psychiatric facility
<b>Temporary and Permanent</b>	<input type="checkbox"/> Substance abuse treatment facility or detox center
	<input type="checkbox"/> Residential project or halfway house with no homeless criteria
	<input type="checkbox"/> Hotel or motel paid for <i>without</i> emergency shelter voucher
	<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)
	<input type="checkbox"/> Host Home (non-crisis)
	<input type="checkbox"/> Staying or living in friends, temporary tenure (e.g. room, apartment or house)
	<input type="checkbox"/> Staying or living with family, temporary tenure (e.g. room, apartment or house)
<input type="checkbox"/> Staying or living with family, permanent tenure	

<b>Temporary and Permanent (cont.)</b>	<input type="checkbox"/> Staying or living in friends, permanent tenure
	<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"/> Rental by client, with GPD TIP housing subsidy
	<input type="checkbox"/> Rental by client, with VASH housing subsidy
	<input type="checkbox"/> Permanent housing (other than RRH) for formerly homeless persons
	<input type="checkbox"/> Rental by client, with RRH or equivalent subsidy
	<input type="checkbox"/> Rental by client, with HCV voucher (tenant or project based)
	<input type="checkbox"/> Rental by client in a public housing unit
	<input type="checkbox"/> Rental by client, no ongoing housing subsidy
	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy
	<input type="checkbox"/> Owned by client, no ongoing housing subsidy
	<input type="checkbox"/> Owned by client, with ongoing housing subsidy
	<b>Other</b>
<input type="checkbox"/> Other (specify):	
<input type="checkbox"/> Deceased:	
<input type="checkbox"/> Client doesn't know	
<input type="checkbox"/> Client refused	
<input type="checkbox"/> Data not collected	

<b>NOTES – Reason or Destination details</b>

<b>NC COUNTY OF SERVICE</b> In which NC county is this client receiving your project's services?	
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<b>DISABILITY STATUS - Does the client have a disabling condition?</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**Answer 'Yes' or 'No' for each disability type (in white).**  
 If the client selects 'Yes' for any disability type, you must also complete the shaded sections below.

Disability Type	Yes	No	Disability Determination	Expected to be of long-continued and indefinite duration and substantially impairs client's ability to live independently?	Start Date (MM/DD/YYYY)
Physical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Chronic Health Con	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Developmental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Both Alcohol & Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	
Mental Health Prob.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> CDK <input type="checkbox"/> CR <input type="checkbox"/> DNC	

<b>HEALTH INSURANCE - Is the client currently covered by health insurance?</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**Answer 'Yes' or 'No' for each health insurance source.**  
 Answer 'Yes' for a source that is currently received.  
 Answer 'No' for sources that have been terminated, even if they were received in the past.  
 If the client selects 'Yes' for any insurance type, complete the shaded section below.

Health Insurance Type	Yes	No	Start Date (MM/DD/YYYY)
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>	
Medicare	<input type="checkbox"/>	<input type="checkbox"/>	
State Children's Health Insurance Program (or use local name)	<input type="checkbox"/>	<input type="checkbox"/>	
Veteran's Administration (VA) Medical Services	<input type="checkbox"/>	<input type="checkbox"/>	
Employer-Provided Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	
Health insurance obtained through COBRA	<input type="checkbox"/>	<input type="checkbox"/>	
Private Pay Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>	
State Health Insurance for Adults	<input type="checkbox"/>	<input type="checkbox"/>	
Indian Health Services Program	<input type="checkbox"/>	<input type="checkbox"/>	
Other If Yes, specify source:	<input type="checkbox"/>	<input type="checkbox"/>	

## ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLD AND OTHER ADULTS

<b>INCOME AND SOURCES - Does the client currently have any income from any source?</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**To complete the table below, you must answer 'Yes' or 'No' for each income source.**  
 Answer 'Yes' only if the income source is recurrent and received as of today (i.e. not terminated).  
 Answer 'No' for sources that have been terminated, even if they were received in the past.  
**If the response for any source is 'Yes', complete the shaded sections below.**  
 Enter the start date and monthly amount received. If unsure of the exact amount, enter the client's best estimate.  
 Children's income (except earned income) can be included under the Head of Household's information.

Source of Income	Yes	No	If yes, monthly amount from source (round to nearest dollar)	Start Date (MM/DD/YYYY)
Earned income (i.e., employment income)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Supplemental Security Income (SSI)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Social Security Disability Income (SSDI)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
VA Service-Connected Disability Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	
VA Non-Service-Connected Disability Pension	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Private disability insurance	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Temporary Assistance for Needy Families (TANF)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
General Assistance (GA)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Retirement Income from Social Security	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Pension or retirement income from a former job	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Child support	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Alimony or other spousal support	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$	
<b>Total monthly income from all sources</b>			\$	

<b>NON-CASH BENEFITS - Does the client have any non-cash benefits from any source?</b>				
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Client doesn't know	<input type="checkbox"/> Client refused	<input type="checkbox"/> Data not collected

**To complete the table below, you must answer 'Yes' or 'No' for each non-cash benefit.**  
 Answer 'Yes' only if the non-cash benefit is recurrent and received as of today (i.e. not terminated).  
 Answer 'No' for non-cash benefit that have been terminated, even if they were received in the past.  
**If the response for any non-cash benefit is 'Yes', complete the shaded section.**

Source of Non-Cash Benefit	Yes	No	If yes, monthly amount from source (round to nearest dollar)	Start Date (MM/DD/YYYY)
Supplemental Nutrition Assistance Program (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	<input type="checkbox"/>	<input type="checkbox"/>	\$	
TANF Child Care services <i>(or use local name)</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
TANF transportation services <i>(or use local name)</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other TANF-Funded Services <i>(or use local name)</i>	<input type="checkbox"/>	<input type="checkbox"/>	\$	
Other source:	<input type="checkbox"/>	<input type="checkbox"/>	\$	

**ANSWER THESE QUESTIONS FOR HEAD OF HOUSEHOLDS ONLY**

<b>COORDINATED ENTRY EVENT</b>											
<b>START DATE / DATE OF EVENT</b>							/			/	
<b>EVENT</b>											
<b>Access Events</b>	<input type="checkbox"/> Referral to Prevention Assistance project										
	<input type="checkbox"/> Problem Solving/Diversion/Rapid Resolution							<b>→ Go to A</b>			
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Crisis Needs Assessment										
	<input type="checkbox"/> Referral to scheduled Coordinated Entry Housing Needs Assessment							<b>→ Go to B</b>			
<b>Referral Events</b>	<input type="checkbox"/> Referral to post-placement/follow-up case management										
	<input type="checkbox"/> Referral to Street Outreach project or services										
	<input type="checkbox"/> Referral to Housing Navigation project or services										
	<input type="checkbox"/> Referral to Non-continuum services: Ineligible for continuum services										
	<input type="checkbox"/> Referral to Non-continuum services: No availability in continuum services										
	<input type="checkbox"/> Referral to Emergency Shelter bed opening							<b>→ Go to C</b>			
	<input type="checkbox"/> Referral to Transitional Housing bed/unit opening										
	<input type="checkbox"/> Referral to Joint TH-RRH project/unit/resource opening										
	<input type="checkbox"/> Referral to RRH project resource opening										
	<input type="checkbox"/> Referral to PSH project resource opening										
<input type="checkbox"/> Referral to Other PH project/unit/resource opening											
<input type="checkbox"/> Referral to Other PH project/unit/resource opening											
<b>If 'Event' answer was 'Problem Solving/Diversion/Rapid Re-Housing intervention or service result', please answer the following question:</b>											
<b>A. Problem Solving/Diversion/Rapid Resolution intervention or service result – Client housed/re-housed in a safe alternative?</b>					<input type="checkbox"/> Yes			<input type="checkbox"/> No			
<b>If 'Event' answer was 'Referral to post-placement/follow-up case management result', please answer the following question:</b>											
<b>B. Referral to post-placement/follow-up case management result – Enrolled in Aftercare project?</b>					<input type="checkbox"/> Yes			<input type="checkbox"/> No			
<b>If 'Event' answer was Referral to an ES, TH, Joint TH-RRH, RRH, PSH, or Other PH opening, please answer the following questions</b>											
<b>C. Location of Crisis Housing or Permanent Housing Referral (project name)</b>											
<b>D. Referral Result</b>					<input type="checkbox"/> Client accepted		<input type="checkbox"/> Client rejected		<input type="checkbox"/> Provider rejected		
<b>E. Date of Result</b>							/			/	