

**Bridging the Gap – Emergency Shelter, Transitional Housing,
Rapid Re-housing, Permanent Supportive Housing**

Adult Exit Form

Last Name* _____ First Name* _____
Exit Date* _____ Alias _____
Project (Program)* _____
Case Worker _____ Last 4 digits of SSN _____

HUD Program Data

Exit Destination*

- Emergency shelter including hotel or motel paid with emergency shelter voucher or RHY funded Host Home Shelter
- Place not meant for habitation – unsheltered, living on the street, beach, part, etc.
- Safe Haven

INSTITUTIONAL SITUATIONS:

- Psychiatric hospital or other psychiatric facility
- Substance abuse treatment facility or detox center
- Hospital or other residential non-psychiatric medical facility
- Long-term care facility or nursing home
- Foster care home or foster care group home
- Jail, prison, or juvenile detention facility

TEMPORARY AND PERMANENT SITUATIONS:

- Transitional housing for homeless persons (including homeless youth)
- Permanent housing (other than RRH) for formerly homeless persons
- Rental by client, no on-going housing subsidy
- Owned by client, no on-going housing subsidy
- Staying or living with family, temporary tenure
- Staying or living with friends, temporary tenure
- Hotel/motel paid for without emergency shelter voucher
- Rental by client with VASH housing subsidy
- Rental by client, other ongoing housing subsidy (Low-income housing, Section 8)
- Owned by client, with housing subsidy
- Staying or living with family, permanent tenure
- Staying or living with friends, permanent tenure
- Moved from HOPWA funded project to HOPWA PH
- Moved from HOPWA funded project to HOPWA TH
- Rental by client, GPD TIP housing subsidy
- Residential project or halfway house; no homeless criteria
- Rental by client, with RRH or equivalent subsidy
- Host Home non-crisis
- Rental by client with HCV voucher (tenant or project based)
- Rental by client in a public housing unit

OTHER:

- No exit interview completed
- Client doesn't know
- Deceased
- Client refused
- Other _____
- Data not collected

Non-Cash Benefits from Any Sources*

Have you received any non-cash benefits in the past 30 days and expect to receive them again next month?

- No
- Yes
- Client doesn't know
- Client Refused
- Data not collected

If yes, please mark all that are applicable:

- SNAP (Previously Known as Food Stamps)
- Section 8, Public Housing, Other Ongoing Rental Assistance
- WIC-Nutrition for Women, Infants, Children
- TANF Child Care Services
- Other source: _____
- TANF Transportation Services
- Other TANF-Funded Services
- Temporary Rental Assistance

Health Insurance*

Are you covered by health insurance?

- No
- Yes
- Client doesn't know
- Client Refused
- Data not collected

HUD Program Data (Continued)

Disabling Condition

Substance Use Disorder* (If “NO” selected, skip to Mental Health)

- No Drug Use Disorder Both Alcohol and Drug Use Disorder
 Alcohol Use Disorder Client doesn't know Client Refused Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

- No Yes Client doesn't know Client Refused Data not collected

Mental Health Disorder* (If “NO” selected, skip to Developmental Disability)

- No Yes Client doesn't know Client Refused Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

- No Yes Client doesn't know Client Refused Data not collected

Developmental Disability* (If “NO” selected, skip to Chronic Health Condition)

- No Yes Client doesn't know Client Refused Data not collected

Chronic Health Condition* (If “NO” selected, skip to HIV / AIDS)

- No Yes Client doesn't know Client Refused Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

- No Yes Client doesn't know Client Refused Data not collected

HIV / AIDS* (If “NO” selected, skip to Physical Disability) (as applicable)

- No Yes Client doesn't know Client Refused Data not collected

Physical Disability* (If “NO” selected, skip to Health Insurance Assessment)

- No Yes Client doesn't know Client Refused Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

- No Yes Client doesn't know Client Refused Data not collected

Health Insurance Assessment (if yes to health insurance)

- | | |
|---|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Health Insurance through Cobra |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> State Health Insurance for Adults |
| <input type="checkbox"/> State Children's Health Insurance | <input type="checkbox"/> Private Insurance |
| <input type="checkbox"/> VA-Veteran's Administration Medical Services | <input type="checkbox"/> Indian Health Services Program |
| <input type="checkbox"/> Employer-Provided Health Insurance | <input type="checkbox"/> Other _____ |

HUD Financial Assessment

Area Median Income* Big Island Kauai Maui

Income from Any Source* No Yes Client doesn't know Client Refused Data not collected

Please check all resources and enter the amount per MONTH*

<u>Income Type</u>	<u>Amount</u>	<u>Income Type</u>	<u>Amount</u>
<input type="checkbox"/> Earned Income (employment): _____	\$ _____	<input type="checkbox"/> TANF _____	\$ _____
<input type="checkbox"/> Unemployment _____	\$ _____	<input type="checkbox"/> Government Assistance: _____	\$ _____
<input type="checkbox"/> SSI: _____	\$ _____	<input type="checkbox"/> Social Security Retirement: _____	\$ _____
<input type="checkbox"/> SSDI: _____	\$ _____	<input type="checkbox"/> Pension or Retirement Income (job): _____	\$ _____
<input type="checkbox"/> VA Service Disability Compensation: _____	\$ _____	<input type="checkbox"/> Child Support: _____	\$ _____
<input type="checkbox"/> VA Non-Service Disability Pension _____	\$ _____	<input type="checkbox"/> Alimony or Other Spousal Support: _____	\$ _____
<input type="checkbox"/> Private Disability Insurance: _____	\$ _____	<input type="checkbox"/> Other: _____	\$ _____
<input type="checkbox"/> Worker's Compensation: _____	\$ _____	TOTAL INCOME:	\$ _____

Hawaii Specific Data Elements Assessment

If currently working, # of hours worked in the past week: _____

Medical Insurer: _____

Reason for Exit*:

- | | |
|---|--|
| <input type="checkbox"/> Unknown/disappeared/abandoned unit | <input type="checkbox"/> Disagreement with rules/persons |
| <input type="checkbox"/> Successfully moved into housing | <input type="checkbox"/> Death |
| <input type="checkbox"/> Completed program | <input type="checkbox"/> Institutionalized: jail, hospital, SA treatment |
| <input type="checkbox"/> Nonpayment of rent/program fees | <input type="checkbox"/> Moved out of state: mainland |
| <input type="checkbox"/> Noncompliance with program | <input type="checkbox"/> Moved out of state: Compact of Free Association |
| <input type="checkbox"/> Criminal activity/destruction of property/violence | <input type="checkbox"/> Moved out of state: out of country |
| <input type="checkbox"/> Reached maximum time allowed by program | <input type="checkbox"/> Moved to different Island within State |
| <input type="checkbox"/> Needs could not be met by program | <input type="checkbox"/> Other: _____ |

Forwarding Address: _____

Exit Destination: If ES, TH, or PH, which program? _____