**NEBRASKA EXIT ASSESSMENT**

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| **PROGRAM EXIT DATE** |
|  |  | **/** |  |  | **/** |  |  |  |  |

# Month Day Year

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| **CLIENT NAME** |  | **HMIS CLIENT ID - For HMIS Users only** |
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| **REASON FOR LEAVING** |
|  | Completed program |  | Reached maximum time allowed |
|  | Criminal activity/violence |  | Not eligible – Over Income |
|  | Death/Deceased |  | Not eligible – Not Homeless |
|  | Disagreement with rules/persons |  | Not eligible |
|  | Left for housing opportunity before completing program |  | Moved out of state  |
|  | Needs could not be met |  | Unknown/Disappeared  |
|  | Non-compliance with program |  | Other |
|  | Non-payment of rent |  |  |

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| **DESTINATION – Where will the client be staying right after leaving this project?** |
| **Homeless** |  | Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train station, airport or anywhere outside) |
|  | Emergency shelter, including hotel or motel paid for with emergency shelter voucher or RHY-funded Host Home shelter |
|  | Safe Haven |
| **Institutional** |  | Foster care home or foster care group home |
|  | Hospital or other residential non-psychiatric medical facility |
|  | Jail, prison or juvenile detention facility |
|  | Long-term care facility or nursing home |
|  | Psychiatric hospital or other psychiatric facility |
|  | Substance abuse treatment facility or detox center |
| **Temporary and Permanent Housing** |  | Residential project or halfway house with no homeless criteria |
|  | Hotel or motel paid for without emergency shelter voucher |
|  | Transitional housing for homeless persons (including homeless youth) |
|  | Host Home (non-crisis) |
|  | Staying or living with friends, temporary tenure (e.g. room, apartment or house) |
|  | Staying or living with family, temporary tenure (e.g. room, apartment or house) |
|  | Staying or living with family, permanent tenure  |
|  | Staying or living with friends, permanent tenure  |
|  | Moved from one HOPWA funded project to HOPWA PH |
|  | Moved from one HOPWA funded project to HOPWA TH |
|  | Rental by client, with GPD TIP housing subsidy |
|  | Rental by client, with VASH housing subsidy |
|  | Permanent housing (other than RRH) for formerly homeless persons |
|  | Rental by client, with RRH or equivalent subsidy |
|  | Rental by client with HVC voucher (tenant or project based) |
|  | Rental by client in a public housing unit |
|  | Rental by client, no ongoing housing subsidy |
|  | Rental by client with other ongoing housing subsidy |
|  | Owned by client with ongoing housing subsidy |
|  | Owned by client, no ongoing housing subsidy |
| **Other** |  | No exit interview completed  |
|  | Other |
|  | Deceased |
|  | Client doesn’t know |
|  | Client refused |
|  | Data not collected |

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| **IN PERMANENT HOUSING** (Permanent Housing Projects, for Head of Household) |
|  | No |  | Yes **IF “YES” Housing Move-In Date\*:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_ |
| **\* If client moved into permanent housing, make sure to update move-in date on the enrollment screen.** |

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| **HOUSING ASSESSMENT AT EXIT** (Homeless Prevention Only) |
|  | Able to maintain the housing they had at project entry |  | Moved in with family/friends on a temporary basis |
|  | **If selected, please indicate Subsidy Information:** |  | Moved in with family/friends on a permanent basis |
|  |  Without a subsidy |  | Moved to a transitional or temporary housing facility |
|  |  With the subsidy they had at project entry | or program |
|  |  With an ongoing subsidy acquired since project entry |  | Client became homeless – moving to a shelter or |
|  |  Only with financial assistance other than a subsidy | other place unfit for human habitation |
|  | Moved to a new housing unit |  | Client went to jail/prison  |
|  | **If selected, please indicate Subsidy Information:** |  | Client doesn’t know  |
|  |  With ongoing subsidy |  | Client refused |
|  |  Without an ongoing subsidy |  | Data not collected |

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| **DISABLING CONDITION** |
|  | Yes |   |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **Answer ‘Yes’ or ‘No’ for each disability type.** If the client selects ‘Yes’ for Physical, Chronic, Mental Health or any of the three Substance Use Disorders, you must also complete the shaded sections below. |
| **Disability Type** | **Yes** | **No** | **If Yes: Expected to be of long-continued and indefinite duration and** **substantially impairs client’s ability to live independently?** |
| Physical Disability |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Developmental Disability  |  |  |  |  |  |  |  |
| Chronic Health Condition  |  |  |  Yes |  No |  CDK |  CR |  DNC |
| HIV/AIDS |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Substance Use Disorder: |  |  |  |  |  |  |  |
| Alcohol use disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Drug use disorder |  |  |  Yes |  No |  CDK |  CR |  DNC |
| Both alcohol and drug use disorders |  |  |  Yes |  No |  CDK |  CR |  DNC |

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| **INCOME FROM ANY SOURCE – Do the head of household or any adults currently have any income from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If “YES” to Income from any Source, indicate Yes or No and the amount for all sources that apply.** **To complete the table below, you must answer ‘Yes’ or ‘No’ for each income source.**Answer ‘Yes’ only if the income source is current 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’, enter the monthly amount received from that source to the nearest dollar.**  |
| **Source of Income** | **Yes** | **No** | **If yes, monthly amount from source** **(round to nearest dollar)** |
| Earned Income (from job)  |  |  | $ |
| Unemployment Insurance  |  |  | $ |
| Supplemental Security Income (SSI)  |  |  | $ |
| Social Security Disability Insurance (SSDI)  |  |  | $ |
| VA Service-Connected Disability Compensation  |  |  | $ |
| VA Non-Service-Connected Disability Pension  |  |  | $ |
| Private Disability Insurance |  |  | $ |
| Worker’s Compensation  |  |  | $ |
| Temporary Assistance for Needy Families (TANF) |  |  | $ |
| General Assistance (GA)  |  |  | $ |
| Retirement income from Social Security |  |  | $ |
| Pension or retirement income from a former job  |  |  | $ |
| Child support |  |  | $ |
| Alimony and other spousal support  |  |  | $ |
| Other income source (specify): |  |  | $ |
| **Total monthly income from all sources** | $ |

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| **NON-CASH BENEFITS - Do the head of household or any adults receive non-cash benefits from any source?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **To complete the table below, you must answer ‘Yes’ or ‘No’ for each source of 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 benefits 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)** |
| Supplemental Nutrition Assistance Program (SNAP) |  |  | $ |
| Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |  |  | $ |
| TANF Child Care Services  |  |  | $ |
| TANF Transportation Services  |  |  | $ |
| Other TANF-funded Services  |  |  | $ |
| Other Non-Cash Benefit (specify): |  |  | $ |

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| **HEALTH INSURANCE - Is the client currently covered by health insurance?** |
|  | Yes |  | No |  | Client doesn’t know |  | Client refused |  | Data not collected |
| **If YES to Health Insurance, check all coverage that applies:** |
|  | Medicaid |  | Health Insurance obtained through COBRA  |
|  | Medicare |  | Private Pay Health Insurance  |
|  | State Children’s Health Insurance Program (SCHIP) |  | State Health Insurance for Adults |
|  | Veteran’s Administration (VA) Medical Services  |  | Indian Health Services Program |
|  | Employer-Provided Health Insurance  |  | Other (specify): |

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| **Client perceives their life has value and worth.** |
|  | Strongly disagree |  | Somewhat agree |  | Client doesn’t know  |
|  | Somewhat disagree |  | Strongly agree |  | Client refused  |
|  | Neither agree nor disagree |  |  |  | Data not collected |

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| **Client perceives they have support from others who will listen to problems.** |
|  | Strongly disagree |  | Somewhat agree |  | Client doesn’t know  |
|  | Somewhat disagree |  | Strongly agree |  | Client refused  |
|  | Neither agree nor disagree |  |  |  | Data not collected |

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| **Client perceives they have a tendency to bounce back after hard times.** |
|  | Strongly disagree |  | Somewhat agree |  | Client doesn’t know  |
|  | Somewhat disagree |  | Strongly agree |  | Client refused  |
|  | Neither agree nor disagree |  |  |  | Data not collected |

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| **Client frequency of feeling nervous, tense, worried, frustrated, or afraid.** |
|  | Not at all |  | Several times a week  |  | Client doesn’t know  |
|  | Once a month |  | At lease every day |  | Client refused  |
|  | Several times a month |  |  |  | Data not collected |

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| **GENERAL HEALTH STATUS** |
|  | Excellent |  | Poor |
|  | Very Good |  | Client doesn’t know |
|  | Good |  | Client refused |
|  | Fair |  | Data not collected |

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| **CLIENT’S CURRENT ADDRESS** |
| Street Address: |
| City: | State: | ZIP Code: |
| County of Current Residence: | Phone #: |

**EXIT ASSESSMENT FOR CHILDREN IN THE HOUSEHOLD**

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| **Last Name** | **First Name** | **MI** | **Suffix** | **See Codes Below** |
| **Covered by Health Insurance?\*** | **Disabling Condition****\*** |
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| **\* Health Insurance:** **Y**=Yes **N**=No **DK**=Client Doesn’t Know **CR**=Client Refused **If YES, check all that apply:** Medicaid  Medicare  CHIP  Veteran’s Affairs  Employer  COBRA  Private Pay  Indian Health Services  Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **\* Disabling Condition:** **Y**=Yes **N**=No **DK**=Client Doesn’t Know **CR**=Client Refused **If YES, check all that apply:** Physical  Developmental Disability  Chronic Health Condition  HIV/AIDS  Mental Health Disorder**Substance Use Disorder**:  Alcohol use disorder  Drug use disorder  Both alcohol & drug use disorders |