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hhc@unitedway-cny.org  
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**Permanent Supportive Housing Exit Assessment (Single Individual and Head of Household)**

(complete this form for ALL HH members)

**Client Name:** \_\_\_\_\_

HMIS Client ID#: \_\_\_\_\_

(optional)

Exit Date: \_\_\_\_\_

**Client Location:** \_\_\_\_\_ NY-505 (Onondaga/ Cayuga/ Oswego counties)

\_\_\_\_\_ NY-510 (Ithaca/ Tompkins County)

**Reason for Leaving:**

- \_\_\_\_\_ Completed Program
- \_\_\_\_\_ Criminal Activity/Violence
- \_\_\_\_\_ Death
- \_\_\_\_\_ Disagreement with Rules
- \_\_\_\_\_ Does not meet criteria for program
- \_\_\_\_\_ Goal Achieved
- \_\_\_\_\_ Goal Not Achieved
- \_\_\_\_\_ Left for housing opportunity before completing program
- \_\_\_\_\_ Needs could not be met
- \_\_\_\_\_ Non-compliance
- \_\_\_\_\_ Non payment of rent
- \_\_\_\_\_ Reached maximum time allowed
- \_\_\_\_\_ Unknown/ Disappeared
- \_\_\_\_\_ Other: \_\_\_\_\_

**Destination:**

-----Homeless Situations -----

- \_\_\_\_\_ Emergency Shelter, incl. hotel/motel paid for w/ES voucher, or RHY funded Host Home shelter
- \_\_\_\_\_ Place not meant for human habitation
- \_\_\_\_\_ Save Haven

----- Institutional Situations -----

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

----- Temporary and Permanent Housing Situations -----

- \_\_\_\_\_ Moved from one HOPWA funded project to HOPWA PH
- \_\_\_\_\_ Moved from one HOPWA funded project to HOPWA TH
- \_\_\_\_\_ No exit interview completed
- \_\_\_\_\_ Owned by client, no ongoing housing subsidy
- \_\_\_\_\_ Owned by client, with ongoing housing subsidy



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- Permanent housing (other than RRH) for formerly homeless persons
- Hotel/ Motel paid for without emergency shelter voucher
- Host Home (non-crisis)
- Residential or halfway house with no homeless criteria
- Rental by client, with GPD TIP subsidy
- Rental by client, with VASH subsidy
- Rental by client with RRH or equivalent subsidy
- Rental by client with Housing Choice Voucher (HCV) (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
- Staying or living with friends, temporary tenure (e.g. room, apartment or house)
- Staying or living with friends, permanent tenure
- Staying or living with family, temporary tenure (e.g. room, apartment or house)
- Staying or living with family, permanent tenure (e.g. room, apartment or house)
- Transitional Housing for Homeless persons (including homeless youth)
- Other Destination -----
- Other: \_\_\_\_\_
- Client Doesn't Know
- Client Refused
- Data Not Collected
- Deceased

**Housing Move In Date:** \_\_\_/\_\_\_/\_\_\_ (Complete for Rapid Re-housing Programs)

**Income:**

**Do you have income?** \_\_\_ Yes \_\_\_ No      **Total Monthly Income \$** \_\_\_\_\_

Income Source and amount: (please write in the monthly amount below for each source)

- |  |   |
|--|---|
| \$___ Alimony/ Spousal Support                     | \$___ Child Support                               |
| \$___ Earned Income                                | \$___ General Assistance                          |
| \$___ Pension/Retirement income from a job         | \$___ Private Disability Insurance                |
| \$___ Retirement Income from Social Security       | \$___ Social Security Disability Income (SSDI)    |
| \$___ Social Security Income (SSI)                 | \$___ Temporary Assist for Needy Families TANF    |
| \$___ Unemployment Insurance                       | \$___ VA Non-Service-Connected Disability Pension |
| \$___ VA Service-Connected Disability Compensation | \$___ Worker's Compensation                       |

**Non-Cash Benefits:**

**Do you have Non-Cash Benefits?** \_\_\_ Yes \_\_\_ No

Source of Non-Cash Benefits:

- Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)
- Special supplemental Nutrition Program for (WIC) (HUD)
- TANF Child Care Services (HUD)
- TANF Transportation Services (HUD)
- Other TANF-Funded Services (HUD); If "Other" Specify: \_\_\_\_\_



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**Medical Insurance:**

**Do you have Health Insurance/ Medical Assistance?** \_\_\_ Yes \_\_\_ No

Source of Health Insurance/ Medical Assistance:

- \_\_\_ Medicaid                      \_\_\_ Medicare
- \_\_\_ State Children’s Health Insurance Program                      \_\_\_ Veteran’s Administration (VA) Medical Services
- \_\_\_ Employer – Provided Health Insurance                      \_\_\_ Health Insurance obtained through COBRA
- \_\_\_ State Health Insurance for Adults
- \_\_\_ Indian Health Care                      \_\_\_ Other

Medicaid ID# \_\_\_\_\_

Medicaid Insurance Company: \_\_\_ Total Care                      \_\_\_ Blue Cross Blue Shield                      \_\_\_ Fidelis

\_\_\_ United Healthcare                      \_\_\_ Molina Healthcare

**Disabling Condition:**

**Do you have a DISABILITY of long duration?** \_\_\_ Yes \_\_\_ No

For each disability, check “LCI” if it is expected to be of long, continued and indefinite duration, substantially impairs the individual’s ability to live independently, and is of such a nature that such ability could be improved by more suitable housing conditions.

**Disability Type:**

- \_\_\_ Yes \_\_\_ LCI Alcohol Use Disorder                      \_\_\_ Yes \_\_\_ LCI BOTH Alcohol & Drug Use Disorder                      \_\_\_ Yes \_\_\_ LCI Drug Use Disorder
- \_\_\_ Yes \_\_\_ LCI Chronic Health Condition                      \_\_\_ Yes \_\_\_ LCI Developmental                      \_\_\_\_\_ HIV/AIDS
- \_\_\_ Yes \_\_\_ LCI Mental Health Disorder                      \_\_\_ Yes \_\_\_ LCI Physical Health

**Well-being Assessment: Information Date:** \_\_\_/\_\_\_/\_\_\_\_\_

Client Perceives their life has value and worth.

- \_\_\_ Strongly disagree    \_\_\_ Somewhat disagree    \_\_\_ Neither agree nor disagree    \_\_\_ Somewhat agree    \_\_\_ Strongly agree

Client Perceives they have support from others who will listen to problems.

- \_\_\_ Strongly disagree    \_\_\_ Somewhat disagree    \_\_\_ Neither agree nor disagree    \_\_\_ Somewhat agree    \_\_\_ Strongly agree

Client perceives they have a tendency to bounce back after hard times.

- \_\_\_ Strongly disagree    \_\_\_ Somewhat disagree    \_\_\_ Neither agree nor disagree    \_\_\_ Somewhat agree    \_\_\_ Strongly agree

Client’s frequency of feeling nervous, tense, worried, frustrated, or afraid.

- \_\_\_ One-time event    \_\_\_ Once a Week    \_\_\_ Twice a Week    \_\_\_ Three Times a Week    \_\_\_ Four or more times a Week
- \_\_\_ Once a Month    \_\_\_ Twice a Month    \_\_\_ Three Times a Month    \_\_\_ Four Times a Month

**Moving On Assistance Provided?** \_\_\_ Yes \_\_\_ No      Date of Moving on Assistance: \_\_\_/\_\_\_/\_\_\_\_\_

Moving on Assistance: Select 1

- \_\_\_ Subsidized housing application
- \_\_\_ Financial assistance for Moving On (e.g., security deposit, moving expenses)
- \_\_\_ Non-financial assistance for Moving On (e.g., housing navigation, transition support)
- \_\_\_ Housing referral/placement



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\_\_\_\_ Other (please specify): \_\_\_\_\_