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
_____ 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
$____ Earned Income
$____ Pension/Retirement income from a job
$____ Retirement Income from Social Security
$____ Social Security Income (SSI)
$____ Unemployment Insurance
$____ VA Service-Connected Disability 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: ___________________________________
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
____Yes __LCI 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
Other (please specify): ________________________________________________________________