**NEBRASKA EXIT**

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| **PROJECT EXIT DATE** |
|  |  | **/** |  |  | **/** |  |  |  |  |

# Month Day Year

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| **CLIENT NAME** |  | **HMIS CLIENT ID - For HMIS Users only** |
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| **DESTINATION** |
| **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, 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 Housing** |  | Transitional housing for homeless persons (including homeless youth)  |
|  | Residential project or halfway house with no homeless criteria  |
|  | Hotel or motel paid for without emergency shelter voucher |
|  | Host Home (non-crisis) |
|  | Staying or living with family, temporary tenure (e.g., room, apartment, or house) |
|  | Staying or living with friends, temporary tenure (e.g., room, apartment, or house) |
| **Permanent Housing** |  | Staying or living with family, permanent tenure |
|  | Staying or living with friends, permanent tenure |
|  | Rental by client, no ongoing housing subsidy |
|  | Rental by client, with ongoing housing subsidy: |
|  |  GPD TIP housing subsidy |
|  |  VASH housing subsidy |
|  |  RRH or equivalent subsidy |
|  |  HCV voucher (tenant or project based) (not dedicated) |
|  |  Public housing unit |
|  |  Rental by client with other ongoing housing subsidy |
|  |  Housing Stability Voucher |
|  |  Family Unification Program Voucher (FUP) |
|  |  Foster Youth to Independence Initiative (FYI) |
|  |  Permanent Supportive Housing |
|  |  Other permanent housing dedicated for formerly homeless persons |
|  | Owned by client with ongoing housing subsidy |
|  | Owned by client, no ongoing housing subsidy |
| **Other** |  | No exit interview completed |
|  | Other (specify): |
|  | Deceased |
|  | Client doesn’t know |
|  | Client prefers not to answer |
|  | Data not collected |

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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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| **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 facilityor program |
|  |  With the subsidy they had at project entry |
|  |  With an ongoing subsidy acquired since project entry |  | Client became homeless – moving to a shelter orother place unfit for human habitation |
|  |  Only with financial assistance other than a subsidy |
|  | Moved to a new housing unit |  | Jail/Prison  |
|  | **If selected, please indicate Subsidy Information:** |  | Client doesn’t know  |
|  |  With ongoing subsidy |  | Client prefers not to answer |
|  |  Without an ongoing subsidy |  | Data not collected |

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| **DISABLING CONDITION** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | 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** | **CDK** | **CPNA** | **DNC** | **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 |  CPNA |  DNC |
| Developmental Disability  |  |  |  |  |  |  |  |  |  |  |
| Chronic Health Condition  |  |  |  |  |  |  Yes |  No |  CDK |  CPNA |  DNC |
| HIV/AIDS |  |  |  |  |  |  |  |  |  |  |
| Mental Health Disorder |  |  |  |  |  |  Yes |  No |  CDK |  CPNA |  DNC |
| Substance Use Disorder |  |  |  |  |  |  |  |  |  |  |
| **If yes for Substance Use Disorder, please indicate:** |  Alcohol use disorder, |  Yes |  No |  CDK |  CPNA |  DNC |
|  Drug use disorder, OR |  Yes |  No |  CDK |  CPNA |  DNC |
|  Both alcohol and drug use disorders |  Yes |  No |  CDK |  CPNA |  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 prefers not to answer |  | Data not collected |
| **If “YES” for Income from any Source, indicate all sources and dollar amounts for the source that apply**  |
| **Source of Income** | **Yes** | **No** | **Monthly Amount**  |
| Earned Income (i.e., employment income)  |  |  | $ |
| 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 prefers not to answer |  | Data not collected |
| **If “YES” for Non-Cash Benefits, indicate all sources that apply**  |
|  | Supplemental Nutrition Assistance Program (SNAP)(Previously known as Food Stamps) |  | TANF Child Care Services  |
|  | TANF Transportation Services  |
|  | Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) |  | Other TANF-funded Services  |
|  | Other Non-Cash Benefit (specify): |

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| **COVERED BY HEALTH INSURANCE** |
|  | Yes |  | No |  | Client doesn’t know |  | Client prefers not to answer |  | Data not collected |
| **If YES for Covered by Health Insurance, indicate all sources that apply** |
|  | **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 Health Administration (VHA) |  | Indian Health Services Program |
|  | Employer-Provided Health Insurance  |  | Other (specify): |
| **\* If you do not have Medicaid, have you applied for Medicaid?** |  | Yes |  | No |
| **\* If you have Medicaid or have applied for Medicaid,** may we share your contact information with the Department of Health & Human Services Medicaid and Long-term Care Division so you can receive information about Medicaid from a managed care organization? |  | Yes |  | No |

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| **CLIENT’S CURRENT ADDRESS** |
| Street Address: |
| City: | State: | ZIP Code: | County: |

**EXIT ASSESSMENT FOR CHILDREN IN THE HOUSEHOLD**

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| **Last Name** | **First Name** | **MI** | **Suffix** | **\* Use Codes Listed Below \*** |
| **Health Insurance****(all applicable)** | **Disabling Condition****(all applicable)** |
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| **Health Insurance:** **CAID**=Medicaid **CARE**=Medicare **SCHIP**=State Children’s Health Insurance Program **VHA**=Veteran’s Health Administration **EMP**=employer-provided **COBRA**=health insurance obtained through COBRA **PP**=private pay **SHIA**=State Health Insurance for Adults **IHSP**=Indian Health Services Program **N**=no health insurance coverage **DK**=client doesn’t know **PNA**=client prefers not to answer **OTH**=other (please specify) |
| **Disabling Condition: P or PLT**=physical disability or long-term physical disability **CH or CHLT**=chronic health condition or long-term chronic health condition **MH or MHLT**=mental health disorder or long-term mental health disorder **DD**=Developmental Disability **HIV**=HIV/AIDS **AU or AULT**=alcohol use disorder or long-term alcohol use disorder **DU or DULT**=Drug use disorder or Long-term drug use disorder **BO or BOLT**=both alcohol & drug use disorder or long-term alcohol & drug use disorder **N**=no disabling conditions **DK**=client doesn’t know **PNA**=client prefers not to answer |