DRH Exit Assessment

DRH Project Exit Date:_____ Disaster Re-Housing Agency:_____

HMIS #:_____ County (where are you staying now): _____

A. Identification Data

1. First Name	Last Name	Middle Initial

B. Destination

2. Where will the client(s) be staying right after leaving this project?

Temporary Homeless	☐ Place not meant for habitation
	☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher
	☐ Moved from one HOPWA funded project To HOPWA TH
	☐ Transitional Housing for homeless persons (including homeless youth)
Temporary Non-Homeless	☐ Hotel or motel paid for without emergency shelter voucher
	☐ Residential project or halfway house with no homeless criteria
	☐ Staying or living with family, temporary tenure (room, apartment, or house)
	☐ Staying or living with friends, temporary tenure (room, apartment, or house)
Institutional	☐ Psychiatric hospital or other psychiatric facility
	☐ Substance abuse treatment facility or detox center
	☐ Hospital or other residential non-psychiatric medical facility
	☐ Jail, prison, or juvenile detention facility
	☐ Foster care home or foster care group home
	☐ Long-term care facility or nursing home
Permanent	☐ Rental by client, with RRH or equivalent subsidy
	☐ Permanent housing (other than RRH) for formerly homeless persons
	☐ Moved from one HOPWA funded project to HOPWA PH
	☐ Rental by client, with GPD TIP housing subsidy
	☐ Rental by client, with VASH housing subsidy
	☐ Rental by client, with other ongoing housing subsidy
	☐ Owned by client, with ongoing housing subsidy
	☐ Rental by client, no ongoing housing subsidy
	☐ Owned by client, no ongoing housing subsidy
	☐ Staying or living with family, permanent tenure
	☐ Staying or living with friends, permanent tenure
Other	☐ Deceased
	☐ Other
	☐ Client doesn't know (CDK)
	☐ Client refused (CR)
	☐ No exit interview completed (Data Not Collected, DNC)

C. Disabling Conditions

1. Any changes to disabling condition?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

2. Answer 'Yes' or 'No' for each disability type. *If the client selects 'Yes' for any disability type, you must also complete the shaded sections below. Disability Determination confirms the client's response and does not require documentation. Add Start and End dates for changes*

Disability Type	Yes	No	Disability Determination	Expected to be of indefinite duration and substantially impairs client's ability to live independently?	Start Date	End Date
Physical	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Chronic Health Condition	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
HIV/AIDS	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Developmental	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Alcohol Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Drug Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Both Drug and Alcohol Abuse	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		
Mental Health Problem	☐	☐	☐Yes ☐Client does not know ☐No ☐Client refused	☐Yes ☐Client does not know ☐No ☐Client refused		

D. Health Insurance

1. Any changes to health insurance?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

2. Answer 'Yes' or 'No' for each Health Insurance Type. *Add Start and End Dates for changes*

Health Insurance Type	Yes	No	Start Date	End Date
Medicaid	☐	☐		
Medicare	☐	☐		
State Children's Health Insurance Program (or use local name)	☐	☐		

Health Insurance Type	Yes	No	Start Date	End Date
Veteran's Administration (VA) Medical Services	☐	☐		
Employer-Provided Health Insurance	☐	☐		
Health insurance obtained through COBRA	☐	☐		
Private Pay Health Insurance	☐	☐		
State Health Insurance for Adults	☐	☐		
Indian Health Services Program	☐	☐		
Other If Yes, specify source:	☐	☐		

E. Income

1. Any changes to income from any source?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

2. Answer 'Yes' or 'No' for each income source. *If the client selects 'Yes' for any income source, you must also complete the shaded sections below. Add Start and End Dates for changes*

Source of Income	Yes	No	If yes, monthly amount from source	Start Date	End Date
Earned income (i.e., employment income)	☐	☐	$		
Unemployment Insurance	☐	☐	$		
Supplemental Security Income (SSI)	☐	☐	$		
Social Security Disability Income (SSDI)	☐	☐	$		
VA Service-Connected Disability	☐	☐	$		
VA Non-Service-Connected Disability	☐	☐	$		
Private disability insurance	☐	☐	$		
Worker's Compensation	☐	☐	$		
Temporary Assistance for Needy Families	☐	☐	$		
General Assistance (GA)	☐	☐	$		
Retirement Income from Social Security	☐	☐	$		
Pension or retirement income from a	☐	☐	$		
Child support	☐	☐	$		
Alimony or other spousal support	☐	☐	$		
Other source:	☐	☐	$		
Total monthly income from all sources			$		

F. Non-Cash Benefits

1. Any changes to non-cash benefits from any source?

   ☐Yes ☐No ☐ Client does not know ☐Client refused

2. Answer 'Yes' or 'No' for each non-cash benefit. *Add Start and End Date for changes*

Source of Non-Cash Benefit	**Yes**	**No**	**Start Date**	**End Date**
Supplemental Nutrition Assistance Program (SNAP)	☐	☐		
Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	☐	☐		
TANF Child Care services *(or use local name)*	☐	☐		
TANF transportation services *(or use local*	☐	☐		
Other TANF-Funded Services *(or use local*	☐	☐		
Other source:	☐	☐		