

ServicePoint Client ID for Head of Household: _____

This is the cover page for EXIT data that needs to be collected when a household exits from MHT Rapid-Rehousing or MHT Housing Choice Voucher.

In addition to this page, the information on the following pages was collected at program entry and will need to be updated if there have been any changes for each member of the household. Make additional copies as necessary.

Exit from which provider?		<input type="checkbox"/> Shelter Diversion RRH	<input type="checkbox"/> Shelter Diversion Prevention
EXIT Date: ____/____/____			
Reason for Leaving:			
<input type="checkbox"/> Completed Program	<input type="checkbox"/> Left for housing opportunity before completing program	<input type="checkbox"/> Reached maximum time allowed	
<input type="checkbox"/> Criminal Activity/Violence	<input type="checkbox"/> Needs could not be met	<input type="checkbox"/> Unknown/Disappeared	
<input type="checkbox"/> Death	<input type="checkbox"/> Non-compliance with program	<input type="checkbox"/> Other (specify): _____	
<input type="checkbox"/> Disagreement with Rules/Persons	<input type="checkbox"/> Non-payment of rent		
Destination:			
<input type="checkbox"/> Place not meant for habitation	<input type="checkbox"/> Staying or living with family, permanent		
<input type="checkbox"/> Emergency Shelter, including hotel or motel paid for with emergency shelter voucher	<input type="checkbox"/> Staying or living with friends, permanent		
<input type="checkbox"/> Safe Haven	<input type="checkbox"/> Rental by client, with GPD TIP Subsidy		
<input type="checkbox"/> Foster care home or foster care group home	<input type="checkbox"/> Rental by client, with VASH subsidy		
<input type="checkbox"/> Hospital or other residential non-psychiatric medical facility	<input type="checkbox"/> Permanent Housing (other than RRH) for formerly homeless person		
<input type="checkbox"/> Jail, prison or juvenile detention facility	<input type="checkbox"/> Rental by client, with RRH or equivalent		
<input type="checkbox"/> Long-term care facility or nursing home	<input type="checkbox"/> Rental by client, with HCV Voucher (tenant or project based)		
<input type="checkbox"/> Psychiatric hospital or other psychiatric facility	<input type="checkbox"/> Rental by client in a public housing unit		
<input type="checkbox"/> Substance abuse treatment facility or detox center	<input type="checkbox"/> Rental by client, no ongoing housing subsidy		
<input type="checkbox"/> Residential project or halfway house with no homeless criteria	<input type="checkbox"/> Rental by client, with other ongoing housing subsidy		
<input type="checkbox"/> Hotel or motel paid for without emergency shelter voucher	<input type="checkbox"/> Owned by client, with ongoing housing subsidy		
<input type="checkbox"/> Transitional housing for homeless persons (including homeless youth)	<input type="checkbox"/> Owned by client, no ongoing housing subsidy		
<input type="checkbox"/> Host Home (non-crisis)	<input type="checkbox"/> No Exit Interview Completed		
<input type="checkbox"/> Staying or living with friends, temporary	<input type="checkbox"/> Deceased		
<input type="checkbox"/> Staying or living with family, temporary	<input type="checkbox"/> Client Doesn't Know		
	<input type="checkbox"/> Client Refused		
	<input type="checkbox"/> Data not collected		
	<input type="checkbox"/> Other: _____		

HEAD OF HOUSEHOLD (HoH) EXIT Data (page 1 of 1)

Name: _____

Disability Type at Exit: None Client Refused Client Doesn't Know
Mental Health Physical Chronic Health Condition Drug Abuse Alcohol Abuse
HIV/AIDS Hearing Impaired Vision Impaired Developmental
Other: _____

Health Insurance at Exit: None Client Refused Client Doesn't Know
Medicaid (OHP) Medicare VA Medical Services Employer Provided
COBRA Private Pay Other: _____

Continuous and Ongoing Non-Cash Benefits at Exit None Client Refused Client Doesn't Know
Supplemental Nutrition Assistance (SNAP) WIC TANF Child Care Services
TANF Transportation Services Other TANF-Funded Services
(Select all that apply) Other (Describe): _____

Continuous and Ongoing Income at Exit (Fill in all that apply. Do not count if one time, ended, or ending soon):
None Client Refused Client Doesn't Know

Monthly Amount	Monthly Amount
\$ _____ Alimony or Other Spousal Support	\$ _____ Supplemental Security Income (SSI)
\$ _____ Child Support	\$ _____ TANF
\$ _____ Earned Income (wages, salary, etc)	\$ _____ Unemployment Insurance
\$ _____ General Assistance	\$ _____ VA Non-Service Connected Disability Pension
\$ _____ Pension or retirement income	\$ _____ VA Service Connected Disability Compensation
\$ _____ Private Disability Insurance	\$ _____ Worker's Compensation
\$ _____ Retirement Income from Social Security	\$ _____ Other:
\$ _____ Social Security Disability Insurance (SSDI)	_____

For each additional adult in the household, please make copies of this section.

OTHER ADULT (18+ yrs of age) EXIT Data (page 1 of 1)

Name: _____

Disability Type at Exit: None Client Refused Client Doesn't Know
Mental Health Physical Chronic Health Condition Drug Abuse Alcohol Abuse
HIV/AIDS Hearing Impaired Vision Impaired Developmental
Other: _____

Health Insurance at Exit: None Client Refused Client Doesn't Know
Medicaid (OHP) Medicare VA Medical Services Employer Provided
COBRA Private Pay Other: _____

Continuous and Ongoing Non-Cash Benefits at Exit (Select all that apply) None Client Refused Client Doesn't Know
Supplemental Nutrition Assistance (SNAP) WIC TANF Child Care Services
TANF Transportation Services Other TANF-Funded Services
Other (Describe): _____

Continuous and Ongoing Income at Exit (Fill in all that apply. Do not count if one time, ended, or ending soon):
None Client Refused Client Doesn't Know

Monthly Amount	Monthly Amount
\$_____ Alimony or Other Spousal Support	\$_____ Supplemental Security Income (SSI)
\$_____ Child Support	\$_____ TANF
\$_____ Earned Income (wages, salary, etc)	\$_____ Unemployment Insurance
\$_____ General Assistance	\$_____ VA Non-Service Connected Disability Pension
\$_____ Pension or retirement income	\$_____ VA Service Connected Disability Compensation
\$_____ Private Disability Insurance	\$_____ Worker's Compensation
\$_____ Retirement Income from Social Security	\$_____ Other:
\$_____ Social Security Disability Insurance (SSDI)	_____

For additional children in the household, please make copies of this page.

CHILD (under 18 years of age) EXIT Data (page 1 of 1)

Name: _____						
Disability Type at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	
	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Developmental		
	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Vision Impaired			
	<input type="checkbox"/> Other: _____					
Health Insurance at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know			
	<input type="checkbox"/> Medicaid (OHP)	<input type="checkbox"/> Medicare	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer Provided		
	<input type="checkbox"/> COBRA	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other: _____			

CHILD (under 18 years of age) EXIT Data (page 1 of 1)

Name: _____						
Disability Type at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	
	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Developmental		
	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Vision Impaired			
	<input type="checkbox"/> Other: _____					
Health Insurance at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know			
	<input type="checkbox"/> Medicaid (OHP)	<input type="checkbox"/> Medicare	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer Provided		
	<input type="checkbox"/> COBRA	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other: _____			

CHILD (under 18 years of age) EXIT Data (page 1 of 1)

Name: _____						
Disability Type at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Alcohol Abuse	
	<input type="checkbox"/> Mental Health	<input type="checkbox"/> Physical	<input type="checkbox"/> Chronic Health Condition	<input type="checkbox"/> Developmental		
	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hearing Impaired	<input type="checkbox"/> Vision Impaired			
	<input type="checkbox"/> Other: _____					
Health Insurance at Exit:	<input type="checkbox"/> None	<input type="checkbox"/> Client Refused	<input type="checkbox"/> Client Doesn't Know			
	<input type="checkbox"/> Medicaid (OHP)	<input type="checkbox"/> Medicare	<input type="checkbox"/> VA Medical Services	<input type="checkbox"/> Employer Provided		
	<input type="checkbox"/> COBRA	<input type="checkbox"/> Private Pay	<input type="checkbox"/> Other: _____			