Bridging the Gap - HOPWA Programs   Adult Exit Form

Last Name*_____   First Name*_____

Exit Date*_____   Alias _____

Project (Program)*_____

Case Worker _____   Last 4 digits of SSN _____

HUD Program Data

Exit Destination*

A. HOMELESS SITUATION
- ☐ Emergency shelter including hotel or motel paid with emergency shelter voucher or RHY funded Host Home Shelter
- ☐ Safe Haven
- ☐ Place not meant for habitation – unsheltered, living on the street, beach, part, etc.

B. INSTITUTIONAL SITUATION
- ☐ 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

C. TEMPORARY HOUSING SITUATION
- ☐ Hotel or motel paid for without emergency shelter voucher
- ☐ Host home (non-crisis)
- ☐ Moved from one HOPWA funded project to HOPWA TH
- ☐ 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)
- ☐ Transitional housing for homeless persons (including homeless youth)
- ☐ Residential project or halfway house with no homeless criteria

D. PERMANENT HOUSING SITUATION
- ☐ Staying or living with family, permanent tenure
- ☐ Moved from one HOPWA funded project to HOPWA PH
- ☐ Rental by client, no ongoing housing subsidy
- ☐ **Rental by client, ongoing housing subsidy*** (select below):
- ☐ Staying or living with friends, permanent tenure
- ☐ Owned by client, with ongoing housing subsidy
- ☐ Owned by client, no ongoing housing subsidy

  * Subsidy type:
  - ☐ Housing stability voucher
  - ☐ Family unification program voucher (FUP)
  - ☐ Foster Youth to Independence Initiative (FYI)
  - ☐ HCV voucher (tenant or project based)
  - ☐ GIP TPD housing subsidy
  - ☐ Permanent supportive housing
  - ☐ Public housing unit
  - ☐ Rental by client, with other ongoing housing subsidy
  - ☐ RRH or equivalent
  - ☐ VASH housing subsidy
  - ☐ Other permanent housing dedicated for formerly homeless persons

E. OTHER
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Deceased (*Please update the client demographic form with the deceased date)
- ☐ No exit interview completed
- ☐ Data not collected
- ☐ Other _____

Housing Assessment at Exit*

- ☐ **Able to maintain the housing they had at project entry*** (select below)
  Same housing subsidy info*
  - ☐ Without a subsidy   ☐ With subsidy they had a project entry
  - ☐ With an on-going subsidy acquired since project entry
  - ☐ Only with financial assistance other than a subsidy
- ☐ **Moved to new housing unit*** (select below)
  New housing subsidy info*
  - ☐ With on-going subsidy   ☐ Without an on-going subsidy
- ☐ Moved in with family/friends on a temporary basis
- ☐ Moved in with family/friends on a permanent basis
- ☐ Moved to a transitional or temporary housing facility or program
- ☐ Client became homeless – moving to a shelter or other place unfit for human habitation
- ☐ Client went to jail/prison
- ☐ Client doesn't know
- ☐ Client prefers not to answer
- ☐ Client died
- ☐ Data not collected

HUD Program Data (Continued)

Non-Cash Benefits from Any Sources*(*Received non-cash benefits in the past 30 days; expect to receive them again next month?*)

☐ No ☐ Yes* ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

If yes, please mark all that are applicable:

☐ SNAP (Food Stamps) ☐ TANF Transportation Services

☐ WIC-Nutrition for Women, Infants, Children ☐ Other TANF-Funder Services

☐ TANF Child Care Services ☐ Other source: _____

Health Insurance*

Are you covered by health insurance?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Disabling Condition

Substance Use Disorder* (If "NO" selected, skip to Mental Health)

☐ No ☐ Drug Use Disorder ☐ Both Alcohol and Drug Use Disorder

☐ Alcohol Use Disorder ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Mental Health Disorder* (If "NO" selected, skip to Developmental Disability)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Developmental Disability* (If "NO" selected, skip to Chronic Health Condition)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Chronic Health Condition* (If "NO" selected, skip to HIV / AIDS)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

HIV / AIDS* (If "NO" selected, skip to Physical Disability) (*as applicable*)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Physical Disability* (If "NO" selected, skip to Health Insurance Assessment)

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

a) Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?

☐ No ☐ Yes ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected

Translation Assistance: Translation Assistance Needed*

☐ No ☐ Client doesn't know ☐ Client prefers not to answer ☐ Data not collected ☐ Different preferred language

☐ Yes* **If "Yes", Preferred language:** _____

Health Insurance Assessment (*if yes to health insurance*)

☐ **Medicaid**: ☐ Yes ☐ No*

If "No": ☐ Applied: decision pending ☐ Applied: client not eligible ☐ Client did not apply

☐ Insurance type N/A for client ☐ Client doesn't know ☐ Client prefers not to answer

☐ **Medicare**: ☐ Yes ☐ No*

If "No": ☐ Applied: decision pending ☐ Applied: client not eligible ☐ Client did not apply

☐ Insurance type N/A for client ☐ Client doesn't know ☐ Client prefers not to answer

Health Insurance Assessment (*continued, if yes to health insurance*)

☐ **State Children's Health Insurance**: ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **Employer Provided Health Insurance**:   ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **Health Insurance through COBRA**:   ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **State Health Insurance for Adults**:   ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **VA-Veterans Administration Medical Services**: ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **Private Insurance**:   ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **Indian Health Services Program**: ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

☐ **Other**:_____   ☐ Yes   ☐No*
     If "No": ☐ Applied: decision pending   ☐ Applied: client not eligible   ☐ Client did not apply
           ☐ Insurance type N/A for client   ☐ Client doesn't know   ☐ Client prefers not to answer

HUD Financial Assessment

Area Median Income*   ☐ Big Island   ☐ Kauai   ☐ Maui

Income from Any Source*   ☐ No   ☐ Yes   ☐ Client doesn't know   ☐ Client prefers not to answer   ☐ Data not collected

Please check all resources and enter the amount per MONTH*

Income Type	Amount	Income Type	Amount
☐ Earned Income (employment):	$	☐ TANF	$
☐ Unemployment	$	☐ Government Assistance:	$
☐ SSI:	$	☐ Social Security Retirement:	$
☐ SSDI:	$	☐ Pension or Retirement Income (job):	$
☐ VA Service Disability Compensation:	$	☐ Child Support:	$
☐ VA Non-Service Disability Pension	$	☐ Alimony or Other Spousal Support:	$
☐ Private Disability Insurance:	$	☐ Other:	$
☐ Worker's Compensation:	$	**TOTAL INCOME:**	**$**

Hawaii Specific Data Elements Assessment

If currently working, # of hours worked in the past week: _____

    Medical Insurer: _____

Reason for Exit*:

☐ Unknown/disappeared/abandoned unit   ☐ Disagreement with rules/persons
☐ Successfully moved into housing   ☐ Death
☐ Completed program   ☐ Institutionalized: jail, hospital, SA treatment
☐ Nonpayment of rent/program fees   ☐ Moved out of state: mainland
☐ Noncompliance with program   ☐ Moved out of state: Compact of Free Association
☐ Criminal activity/destruction of property/violence   ☐ Moved out of state: out of country
☐ Reached maximum time allowed by program   ☐ Moved to different Island within State
☐ Needs could not be met by program   ☐ Other: _____

Forwarding Address: _____

Exit Destination: If ES, TH, or PH, which program? _____

HUD HOPWA Data Assessment (*only applicable if client answered "Yes" to the HIV/AIDS disabling condition question above*)

HUD HOPWA:

Receiving AIDS Drug Assistance Program (ADAP)*
    ☐No*   ☐Yes   ☐ Client doesn't know   ☐ Client prefers not to answer   ☐ Data not collected

    If "No", reason*:

☐ Applied: Decision pending   ☐ Client doesn't know
☐ Applied: Client not eligible   ☐ Client prefers not to answer
☐ Client did not apply   ☐ Data not collected
☐ Insurance type N/A for this client

Receiving Ryan White-funded medical or dental assistance*
    ☐No*   ☐Yes   ☐ Client doesn't know   ☐ Client prefers not to answer   ☐ Data not collected

    If "No", reason*:

☐ Applied: Decision pending   ☐ Client doesn't know
☐ Applied: Client not eligible   ☐ Client prefers not to answer
☐ Client did not apply   ☐ Data not collected
☐ Insurance type N/A for this client

T-Cell (CD4) and Viral Load:

T-Cell (CD4) Count Available*
    ☐No   ☐Yes*   ☐ Client doesn't know   ☐ Client prefers not to answer   ☐ Data not collected

    If "Yes", T-Cell count*: _____
    How was the information obtained?
☐ Medical report   ☐ Client report   ☐ Other

Viral Load Information Available*
☐ Not available   ☐ Client doesn't know
☐ Available*   ☐ Client prefers not to answer
☐ Undetectable   ☐ Data not collected

    If "Available", Viral Load count*: _____
    How was the viral load information obtained*
    ☐ Medical report   ☐ Client report   ☐ Other

<u>**Prescribed Anti-Retroviral:**</u>

Date of Information*: _____

    Has the participant been prescribed anti-retroviral drugs?

        ☐No   ☐Yes*   ☐ Client doesn't know   ☐ Client prefers not to answer   ☐ Data not collected