**Logo

Description automatically generated with low confidenceMaryland Balance of State CoC**

Coordinated Entry System

Self Certification of Homelessness

**For Use By: Persons who have experienced homelessness that cannot be verified via HMIS records or a third party.**

Name (Head of Household): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ▢ Individual ▢ Family

|  |  |
| --- | --- |
| **Household Member Name** | **Relationship to Head of Household** |
|  |  |
|  |  |
|  |  |
|  |  |

*▢ Additional names attached*

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Dates Observed**  **(Start date – end date)** | **# Months** | **Location Type** | | | | | **Detailed Description of Living Location(s)** |
| **Eligible Location** | | | **Non-Eligible Location**  ***(Does Not Meet HUD Definition of Literally Homeless)*** | |
|  |  | Street  Emergency Shelter  Safe Haven  Place not meant for habitation | Duration of < 7 days:  Transitional Housing  Hotel/motel not paid by service provider  House owned/rented by client  Residential project  Friends or Family | Duration of < 90 days:  Foster care  Hospital, residential medical facility, or psychiatric facility  Jail, prison, or juvenile detention  Long-term care/nursing home  Substance abuse treatment facility | Duration of >7 days:  Transitional Housing  Hotel/motel not paid by service provider  House owned/rented by client  Residential project  Friends or Family | Duration of >90 days:  Foster care  Hospital, residential medical facility, or psychiatric facility  Jail, prison, or juvenile detention  Long-term care/nursing home  Substance abuse treatment facility |  |
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**Client Certification**

*I certify that the information stated above is true and accurate to the best of my knowledge.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**Staff Acknowledgement**

*I acknowledge that the presented information is true and accurate to the best of my knowledge.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date