**Maryland 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 projectFriends 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