MARYLAND
BALANCE OF STATE
CONTINUUM OF CARE

Maryland Balance of State CoC

Coordinated Entry System
Harford Community Action Agency

This form will be used to enter all clients into the Coordinated Entry System. The questions asked on this form are intended to assist clients in the navigation process and determine project eligibility. Any information omitted on this form will not prevent a client from obtaining housing through the Coordinated Entry System. This form will fulfill all HUD required data elements for all project types.

HMIS#		Entry Date		SSM Score	

Notes	

Client Name	
Client Phone	
Client Email	
Social Security Number	
Date of Birth	
Gender	◯ Male ◯ Female ◯ Transgender MTF ◯ Transgender FTM ◯ Gender Non-Conforming ◯ Other/Declined
Primary Race	◯ American Indian/ Alaskan Native ◯ Asian ◯ Black/African American ◯ Native Hawaiian/ Pacific Islander ◯ White
Secondary Race	◯ American Indian/ Alaskan Native ◯ Asian ◯ Black/African American ◯ Native Hawaiian/ Pacific Islander ◯ White
Ethnicity	◯ Hispanic/Latino ◯ Non-Hispanic/Non-Latino
Has this individual ever served in the U.S. Armed Forces	◯ Yes ◯ No ◯ Don't Know/Refused **Last Grade Completed**

Household Type	◯ Household with Adults & Children ◯ Household without Children ◯ Household with only Children
Household Size	Number of Adults: ____ Number of Children: ____
Relation to Head of Household	◯ Self ◯ Child ◯ Spouse or Partner ◯ Other Relation Member ◯ Non-Relation Member
Is the client currently pregnant?	◯ Yes ◯ No ◯ Don't Know/Refused
If yes, what is the expected due date?	_____ *MM/DD/YYYY*

Have you experienced Domestic Violence?	☐ Yes ☐ No ☐ Don't Know/Refused
If yes, when did it occur?	☐ Within the last 3 month ☐ 3 to 6 months ago ☐ 6 months to 1 year ago ☐ One year ago or more ☐ Don't Know/Refused
If yes, are you currently fleeing?	☐ Yes ☐ No ☐ Don't Know/Refused

Homeless History

Last night, where did this client sleep?	☐ Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside) ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter ☐ Safe Haven ☐ 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 ☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth) ☐ Host Home (non-crisis) ☐ Staying or living in a friend's room, apartment, or house ☐ Staying or living with family, permanent tenure ☐ Staying or living in a family member's room, apartment, or house ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with VASH housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client, with other ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy
Approximately how long was the client staying in that location?	☐ 1 night or less ☐ 2 to 6 nights ☐ One week or more, but less than one month ☐ One month or more, but less than 90 days ☐ 90 days or more, but less than one year ☐ One year or longer ☐ Client doesn't know / Refused
Approximate date homelessness started	_____ *MM/DD/YYYY*
Regardless of where they stayed last night, what is the number of times the client has been homeless in the past three years, including today?	☐ One time ☐ Two times ☐ Three times ☐ Four or more times ☐ Don't know / Refused

Over the last 3 years, approximately how many months did this client spend staying on the streets, in an emergency shelter/safe haven, or in a place not meant for human habitation?	☐ One month *(this time is the first month)* ☐ Two months ☐ Three months ☐ Four months ☐ Five months ☐ Six months ☐ Seven months ☐ Eight months ☐ Nine months ☐ Ten months ☐ Eleven months ☐ Twelve months ☐ More than 12 months ☐ Don't Know/Refused

Disability

Does the individual or anyone in the individual's household have a documented disability?	◯ Yes ◯ No ◯ Don't Know/Refused	
If yes, indicate what type(s)	☐ Physical Disability ☐ Developmental Disability ☐ Chronic Health Condition	☐ HIV/AIDS ☐ Mental Health Problem ☐ Substance Abuse
If yes, is expected to be of long, continued & indefinite duration & substantially impair ability to live independently?	◯ Yes ◯ No ◯ Don't Know/Refused	

Chronicity

Does the individual qualify as **Chronically Homeless** (as defined by HUD below)? ◯ Yes ◯ No ◯ Don't Know/Refused

Chronic Homeless Definition

A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

1. *Currently Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and*
2. *Has been homeless and living as described in paragraph (a) continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (a). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;*
3. *An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or*
4. *A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.*

Income

Does the individual receive any earned income (i.e. employment income)?	◯ Yes ◯ No ◯ Don't Know/Refused
If yes to above: does the individual have any proof of income documents (i.e. paystubs, award letter)?	◯ Yes ◯ No ◯ Don't Know/Refused
If yes, indicate what source(s) & amount	

☐ Employment Income $_____	☐ General Assistance $_____	☐ Pension or retirement from previous job $_____
☐ Unemployment $_____	☐ Retirement Income from Social Security $_____	☐ Child Support $_____
☐ Supplemental Security Insurance $_____	☐ Private Disability Insurance $_____	☐ Alimony or Spousal Support $_____
☐ Social Security Disability Insurance $_____	☐ Worker's Compensation$_____	☐ Other $_____
☐ VA Service Connected $_____	☐ TANF $_____	
☐ VA Non-Service Connected $_____		

Does the individual receive any income from benefits (e.g. SNAP, WIC, etc.)?	◯ Yes ◯ No ◯ Don't Know/Refused
If yes to above: does the individual have any benefits proof of income documents (e.g. award letter, determination letter, etc.)?	◯ Yes ◯ No ◯ Don't Know/Refused

If yes, indicate what source(s)

☐ SNAP $_____ ☐ WIC $_____ ☐ TANF Child Care $_____ ☐ TANF Transportation $_____ ☐ Other $_____

Health Insurance

Is the client currently covered by Health Insurance?	◯ Yes ◯ No ◯ Don't Know/Refused		
If yes, what kind?	☐ Medicaid	☐ VA Medical Services	☐ State Adult Program
	☐ Medicare	☐ Employer Provided	☐ Indian Health Services Program
	☐ State Children's Program (CHIP)	☐ COBRA	☐ Other
		☐ Private Pay	

TOTAL NUMBER OF HOUSEHOLD MEMBERS: _____

Address: Street: _____

_____

City: _____

State: _____

Zip: _____

In spaces below, please fill in ALL household members. List yourself first.

Please use the following choices for "RACE":

1. American Indian/Alaskan Native
2. Asian
3. Black/African American
4. Multi-Race
5. Native Hawaiian/Pacific Islander
6. Other
7. White

First and Last Name	Social Security Number	Date of Birth	Relationship to Applicant	Sex M/F	Race Code	Hispanic/ Latino Yes/No	Marital Status	Disabled Yes/No	Citizen Yes/No	Veteran Yes/No	Highest Level of Education	Type of Health Insurance	Type of Income

Client Agreement:

I declare that the information I have provided Harford Community Action Agency (HCAA) is true, correct and complete. I understand that when this application is signed, permission is given to the HCAA to check all household income, bank accounts, housing expenses, insurance, and other benefits.

If I currently receive or have ever received benefits from the programs administered by the Harford County Department of Social Services (DSS), by signing this application, I give permission to the DSS to share with HCAA any information in my DSS case file needed to complete this application. Such information includes, but is not limited to, household members, income, expenses, resources, child support payments, etc.

I acknowledge that my application information will be stored digitally in the agency database: CAP60. This information will be maintained with the utmost confidentiality, and only HCAA staff will have access to individual files within the database.

Maryland law protects against fraud. Punishment can occur for not telling the truth when applying for assistance from any HCAA program.

Harford Community Action Agency, Inc. prohibits discrimination in all its programs and activities on the basis of race, color, national origin, sex, religion, age, disability, political beliefs, sexual orientation, or marital or family status.

Grievance Process:

If the client wishes to file a grievance, they may do so in writing to the Executive Director stating the situation and their concerns.

The Executive Director must set up an appointment with the client within 14 days of receipt of the letter of grievance to discuss the grievance and reach a solution.

_____ _____ _____

Applicant's Signature **Date** **Intake Worker**

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Coordinated Entry System
HCAA Coordinated Entry Consent and Release of Information Form

Authorization to Share Protected Health Information and Participate in a Housing Assessment

We are here today to talk to you about your housing and service needs. Participation in this assessment is completely voluntary. This survey is our best method to be able to determine if you are eligible for housing assistance in our system and if so, to match you with appropriate housing when it becomes available. If you feel uncomfortable or upset during the assessment, you may ask the interviewer to take a break, skip any question, or stop the assessment.

Please ask **client to initial** below if you agree with the following statements:

___ I agree to allow my responses to this assessment to be disclosed and received by the organizations that participate in the Maryland Balance of State CoC Coordinated Entry System for the purpose of determining eligibility for potential housing placements. The list of participating agencies can be found on the MD BoC CoC website and is updated periodically.

___ I allow the person conducting this assessment to enter my personal information into a HIPAA compliant database. My signature below signifies my permission.

___ I, or the person conducting this assessment, can be contacted about my assessment and responses if more information is needed. All information that I share during this assessment will be kept confidential and will only be used for the purpose of housing placement and service coordination.

___ I understand that the information I provide will be used to determine if I am eligible for participating housing, service and related programs.

___I understand that participating in Coordinated Entry does not guarantee that I will be called to enroll in a housing program.

Important Rights and Other Required Statements You Should Know:

● You may revoke this authorization at any time. To do so, please contact your intake worker or case manager.

● All Coordinated Entry participating organizations agree to use information provided only to link clients with housing or supportive service options.

● This authorization is completely voluntary and you do not have to agree to authorize any use or disclosure.

● You have a right to a copy of this authorization once you have signed it.

Your signature (or mark) below indicates that you have read (or been read) the information provided above, have been provided answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

_____ _____ _____

Signature of Participant Printed Name of Participant Date

_____ _____ _____

Signature of Intake Worker Printed Name of Intake Worker Date

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HCAA Self Certification of Homelessness

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

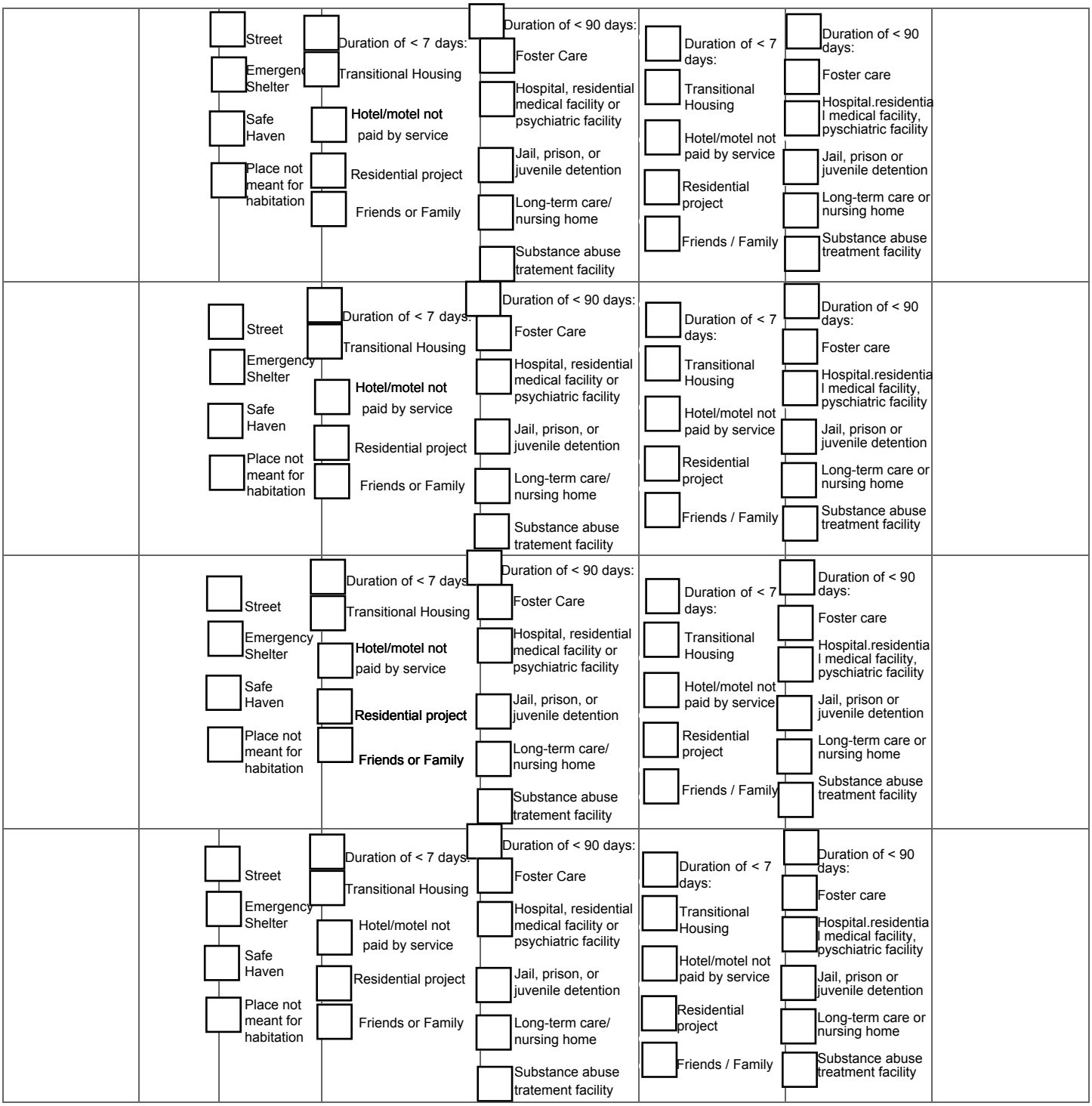
Name (Head of Household):_____

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 ☐ 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 tratement facility	☐ Duration of < 7 days: ☐ Transitional Housing ☐ Hotel/motel not paid by service ☐ Residential project ☐ Friends / Family ☐ Duration of < 90 days: ☐ Foster care ☐ Hospital.residential medical facility, pyschiatric facility ☐ Jail, prison or juvenile detention ☐ Long-term care or nursing home ☐ Substance abuse treatment facility	



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

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Additional Household Members (Continued, if applicable)

Additional Household Member Name	Relationship to Head of Household