Self Report Form
(Reception Centers and Receiving Facility)

Name ___________________________________________  ODOC #_______________

Gender _____  Race _______  Age _____  Number of Prior ODOC Commitments _____________

To be completed by the Inmate: Check any of the following that apply; provide additional explanation where necessary:

Do you have any persons from which you must be separated?  ☐ Yes  ☐ No
If so, list: ________________________________________________________________

Have you ever been convicted for any offense which was against another inmate?  ☐ Yes  ☐ No
If so, list: ________________________________________________________________

Have you ever assaulted or been assaulted by another inmate?  ☐ Yes  ☐ No  Explain.

Have you ever been involved in inmate disturbances?  ☐ Yes  ☐ No  Explain.

Have you ever participated with any group which advocates superiority or aggression towards other groups?  ☐ Yes  ☐ No  Explain.

Is your sexual orientation lesbian, gay, bisexual, transgender, or intersex?  ☐ Yes  ☐ No
If you choose to identify your sexual orientation please circle one of the choices in the list above. (PREA 115.41 (d) (7))
If you answered “no” to the question above, do you believe you are perceived to be a lesbian, gay, bisexual, transgender or intersex?

Do you feel you may be vulnerable and/or at risk for sexual victimization? (PREA 115.41 (d) (8)) If so, explain:

____________________________________________________________________________________________________

To be completed by the screener:

If the inmate answered “yes” to three or more of the questions above, restricted cell/housing and/or referral to Medical/Mental Health Services is required.

After assessment of all information on this inmate, check the applicable housing/cell assignment status below:

_____  Random Eligible/Unrestricted  _____  Restricted

If restricted, explain specific restriction:

____________________________________________________________________________________________________

This is a temporary assignment and will be reevaluated with additional information during intake.

Signature of Screener ___________________________  Date ____________________________

Facility Name___________  Review Date_____________  Signature of Screener ____________________________

Facility Name___________  Review Date_____________  Signature of Screener ____________________________

If the inmate’s status has changed, a new “Self Report Form” must be completed.