

SELF-ASSESSMENT FORM

PERSONAL DATA:

Name: _____
Last First Middle Age

Address: _____

Home Phone: _____ Message Phone: _____

How many people are living in household: _____ How many children: _____

Check which of the following describes your household:

Two Parent __ Single Parent _____ 16-19 yr. old parent without a GED or High School Diploma _____

Are you responsible for caring for a disabled person on a daily basis? Yes _____ No _____

What help do you think you could get from family and friends if you take classes, look for work or if you get a job? _____

Do you work with other community organizations such as HUD, Head Start, CASA, Department of Corrections etc.?

Yes _____ No _____ If YES please tell list the organization: _____

YOUR WORK HISTORY:

How many jobs have you had in the past 18 months? _____

Have you done volunteer work or community services? ___ Yes ___ No

Tell us about your last job, why you left and what would have helped you keep the job. _____

Tell us about your volunteer work or community service. _____

Tell us what kind of job you would like to have and why. _____

You may need to relocate or commute to become employed. Tell us how you feel about that. _____

Have you served in the Military? ___ Are you eligible for Military benefits? ___ if yes, have you applied? _____

YOUR EDUCATION:

What was the highest grade you completed in school? _____ Year? _____ Did you have an IEP? _____

Tell us about any special classes you were in. _____

Tell us about your degrees or certifications. _____

Is this form easy for you to read? _____ If No, tell us why. _____

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YOUR HEALTH:

Do you have medical problems that could affect your working? _____ If Yes, are you under a Doctor's care? _____
Do you or anyone in your home consume alcoholic beverages or non-prescribed Drugs? _____
Has a doctor ever told you to cut down or quit the use of alcohol or drugs? _____
Could you pass an employer's drug screen today? _____

Are you or your children currently being threatened, hurt or harmed in any way by someone in your life (harm can include things like stalking or threatening to hurt you, your children, your pets, or other family or friends, pushing, grabbing, shoving, slapping, hitting, choking or holding you down; constantly putting you down or telling you that you are worthless; any kind of unwanted sexual contact)? _____ Yes _____ No

Could working, looking for work, or going to school put you or your children in danger of physical, emotional or sexual abuse? _____ Yes _____ No

YOUR FINANCES:

What other income do you have that could help you? _____
Are you in danger of: Eviction? _____ Utility shut off? _____
What bills or debt do you owe? _____
Other _____

YOUR STRENGTHS:

Tell us about your strengths and special talents: _____

What help do you need to get started towards the goal of supporting yourself and your family?

- | | | |
|--------------------------------|---------------------------------|----------------------------|
| _____ Child Care | _____ Transportation assistance | _____ Education/training |
| _____ Obtaining Child Support | _____ Drug /Alcohol counseling | _____ Work Experience |
| _____ Help with Domestic Abuse | _____ Need a telephone | _____ Need recertification |
| _____ Work clothing/tools | _____ Need a driver's license | _____ Other |

The above information is correct to the best of my knowledge. Failure to complete this form could result in your application for cash benefits being denied.

SIGNED: _____ DATE: _____

Client's signature

Social Security #: XXX-XX- _____