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._________________________________________________
SELF-ASSESSMENT FORM

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-______________