CUSTOMER/FAMILY NEEDS IDENTIFICATION

Date	Interviewer	Time	Service Center	Region
_____	_____	_____	_____	_____

Customer:		**SSN/DOB:**	
Address:		**Phone#:**	
E-Mail Address:		**Contact Phone #:**	
What brought you here today?			

Language: Spoken_____ **Written:** _____ **Other (Braille, voice synth, Sign, etc.)** _____

Conversation Topics	Strengths	Needs	Service Recommendations (Circle Referrals Made)	Community Resource Referral
Basic Needs Housing Utilities Food Clothing Transportation Money Child Support			CSE TANF/GA CFS APS LIEAP VR Health Care Childcare Food Assistance	
Jobs/Wages Employment Education Training			Rehabilitation Services TANF Work Programs Transitional Support Services Childcare	

Health & Safety Health Insurance Physical Health Mental Health Pregnancy Care Long Term Care Dental Care Child Safety Adult Safety Personal Safety Substance Abuse Rehabilitation Services			Healthwave Medicaid APS CPS Family Preservation OARS RADAC/Treatment HCBS Long Term Care Rehabilitation Services	
Support System Family Friends Church Neighbors Legal Schools				
Early Childhood Early Head Start/Head Start Resource & Referral Parents As Teachers Special Needs Childcare Special Purpose Childcare Quality Childcare			Childcare Special Needs Childcare Special Purpose Childcare	

Comments/Documentation:

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This form is for agency use only. This is an integrated services assessment and customer referral form and is to be used in collaboration with the customer during direct contact either by face-to-face interview or phone interview. It is a guide to help assist in interviewing the customer and helping determine initial needs and to better direct them to services. All requested services along with agency/community referrals must be appropriately marked.