

SNAP E&T ASSESSMENT

(Responses are confidential)



NAME:	DATE:
ADDRESS:	
CITY, STATE, ZIP	
TELEPHONE: (Primary)	(Alternate)
EMAIL:	

EDUCATION

Do you have a High School (HS) Diploma?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• If yes, when did you receive your high school diploma (month/year)?				
• If yes, where did you receive your high school diploma?				
• If no, what is the highest grade level you completed? Select One				
Do you have a General Equivalency Diploma (GED)?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• If yes, when did you receive your GED?				
• If no, are you interested in returning to school to get a HS diploma or GED?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
Are you enrolled in Certification Training or College Degree Program?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• If yes, which have you enrolled?	<input type="checkbox"/>	Short Term Certification Program		
	<input type="checkbox"/>	Vocational Training Program		
	<input type="checkbox"/>	College Degree Program		
• If yes, where are you currently enrolled?				
• If yes, what degree or certification are you seeking?				
• If no, would you like to receive training?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• If yes, what occupation is your training interest?				
Do you have any certifications?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• If yes, what is the name of your certification(s)?	1	_____		
	2	_____		
	3	_____		
• When did you receive your certification(s)?	1	_____		
	2	_____		
	3	_____		
• Is the certification still valid?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• Can you provide a copy of the certification?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO
• Would you like to update the certification?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO

NEEDS AND BARRIERS

Are you employed?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported the employment to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, where do you work?						
• How many hours do you work each week?						
• How much money do you earn each week?						
• If yes, can you provide proof of your employment?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Have you been determined eligible to Receive Re-employment Assistance?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• Can you provide your RA benefits approval letter?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported your RA eligibility to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Do you have a physical or mental condition that prevents you from working?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported your condition to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Are you Pregnant?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported your condition to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Do you receive SSI / SSDI from the Social Security Administration (SSA)?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported this income to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If no, have you applied for SSI/SSDI with SSA?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, what is your disability application status?	<input type="checkbox"/>	DENIED	<input type="checkbox"/>	APPEAL	<input type="checkbox"/>	PENDING
Are you providing care for a disabled or incapacitated adult?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported you are a caregiver to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Are you the caretaker of a child under six (6) year of age?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported you are a caretaker to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Do you reside with a child under 18 years of age?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported your living arrangement to DCF via MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Are you homeless?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, select which applies:						
<input type="checkbox"/> I am temporarily living with a family member.						
<input type="checkbox"/> I am temporarily living with a friend.						
<input type="checkbox"/> I am currently living in a shelter.						
<input type="checkbox"/> I currently have no place to stay.						
• If you currently have no place to stay, would you like to receive a referral to a shelter?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
Are you participating in a Drug and Alcohol Treatment Program?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If yes, have you reported your treatment to DCF via your MyAccess Account?	<input type="checkbox"/>	YES	<input type="checkbox"/>	NO		
• If no, would you like to receive a referral for counseling?		YES	<input type="checkbox"/>	NO		

Do you often feel sad, nervous, agitated or angry?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
• If yes, would you like a referral for counseling?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you use tobacco products?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
• If yes, would you like a referral to the Florida Quitline?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Are you currently on probation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Have you been convicted of a crime?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have any outstanding legal issues?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a job offer, but your background is creating a barrier to the employment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
• If yes, would you like to learn more about the Federal Bonding Program?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you feel unsafe in your home?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
• Check all that apply to why you feel unsafe in your home:		
<input type="checkbox"/> I am afraid of my spouse, mate, or domestic partner who resides <i>inside</i> my home.		
<input type="checkbox"/> I am afraid of my spouse, mate, or domestic partner who resides <i>outside</i> my home.		
<input type="checkbox"/> I am afraid of someone who is not my spouse, mate, or domestic partner living in my home.		
• Would you like domestic counseling?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a car and need help with gas costs to travel for SNAP E&T Participation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you live near public transportation?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you have a current driver's license?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is English your second language?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
• If yes, would you like a referral for ESOL classes?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
EMPLOYABILTY SKILLS		
Do you have any industrial work skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, check all that apply:		
<input type="checkbox"/> CDL License	<input type="checkbox"/> Inventory Control	<input type="checkbox"/> Electronics
<input type="checkbox"/> Assembly	<input type="checkbox"/> Mechanical	<input type="checkbox"/> Welding
<input type="checkbox"/> None of these apply	<input type="checkbox"/> Other: _____	
Do you have any office skills?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
If yes, check all that apply:		
<input type="checkbox"/> Receptionist	<input type="checkbox"/> Bookkeeping	<input type="checkbox"/> Telemarketing
<input type="checkbox"/> Data Entry	<input type="checkbox"/> Microsoft Office – Word	<input type="checkbox"/> Microsoft Office - Excel
<input type="checkbox"/> Typing ≥ 25 words/minute	<input type="checkbox"/> None of these apply	<input type="checkbox"/> Other: _____

Do you have any trade skills?

YES NO

If yes, check all that apply.

Landscaping

Cement/Masonry

Carpentry

Electrical

Roofing

Plumbing

HVAC

Aluminum/Steel

Machinist

None of these apply

Other: _____

Do you have any health care skills?

YES NO

If yes, check all that apply.

Certified Nursing Assistant

Licensed Practical Nurse

Registered Nurse

Medical Billing/Coding

Medical Secretary

Laboratory Technician

Phlebotomist

Dental Assistant

Dental Hygienist

Pharmacy Technician

None of these apply

Other: _____

Do you have any computer skills? If yes, check all that apply

YES NO

If yes, check all that apply.

Help Desk

Networking

Computer Aided Design

Programming

Engineer

Telecommunications

Web Design

None of these apply

Other: _____

Do you have equipment operations skills?

YES NO

If yes, check all that apply.

Warehouse

Agricultural

Mailroom

Printing

Marine

None of these apply

Other: _____

Do you have any retail/food service/hospitality skills.

YES NO

If yes, check all that apply.

Sales

Grocery

Food Preparation

Food Server

Housekeeping

Cashiering

Travel Agents

Airline Counter/Agents

Cruise Line Agents

None of these apply

Other: _____

Do you have any professional skills?

YES NO

If yes, check all that apply.

Accounting

Banking

Fitness

Legal

Childcare

Cosmetology

Education

Outside Sales

Engineering

None of these apply

Other: _____

Do you have any community service skills?

YES NO

If yes, check all that apply.

- | | | |
|---|--|---|
| <input type="checkbox"/> Fire Fighter | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Social Services Worker |
| <input type="checkbox"/> Corrections Officer | <input type="checkbox"/> Security | <input type="checkbox"/> Emergency Management |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ |

CAREER GOALS AND INTERESTS

What are your career goals?

Check all that apply.

Healthcare Occupations:

- | | | |
|---|---|--|
| <input type="checkbox"/> Nursing (CNA,LPN,RN) | <input type="checkbox"/> Physical Therapy/Massage | <input type="checkbox"/> X-Ray Technology |
| <input type="checkbox"/> Pharmacy Technician | <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Dental (Assistant, Hygienist) |
| <input type="checkbox"/> Medical Records/Billing/Coding | <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ |

Professional Occupations:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Accounting | <input type="checkbox"/> Banking | <input type="checkbox"/> Fitness |
| <input type="checkbox"/> Legal | <input type="checkbox"/> Childcare | <input type="checkbox"/> Cosmetology |
| <input type="checkbox"/> Education | <input type="checkbox"/> Outside Sales | <input type="checkbox"/> Engineering |
| <input type="checkbox"/> Drivers – Truck/Bus/Taxi | <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ |

Hospitality/ Food Service/ Retail Occupations:

- | | | |
|--|---|---|
| <input type="checkbox"/> Sales | <input type="checkbox"/> Grocery | <input type="checkbox"/> Food Preparation |
| <input type="checkbox"/> Food Server | <input type="checkbox"/> Housekeeping | <input type="checkbox"/> Cashiering |
| <input type="checkbox"/> Travel Agents | <input type="checkbox"/> Airline Counter/Agents | <input type="checkbox"/> Cruise Line Agents |
| <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ | |

Computer/Technology Occupations:

- | | | |
|--------------------------------------|--|--|
| <input type="checkbox"/> Help Desk | <input type="checkbox"/> Networking | <input type="checkbox"/> Computer Aided Design |
| <input type="checkbox"/> Programming | <input type="checkbox"/> Engineer | <input type="checkbox"/> Telecommunications |
| <input type="checkbox"/> Web Design | <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ |

Trade Occupations:

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Landscaping | <input type="checkbox"/> Cement/Masonry | <input type="checkbox"/> Carpentry |
| <input type="checkbox"/> Electrical | <input type="checkbox"/> Roofing | <input type="checkbox"/> Plumbing |
| <input type="checkbox"/> HVAC | <input type="checkbox"/> Aluminum/Steel | <input type="checkbox"/> Machinist |
| <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ | |

Community Service Occupations:

- | | | |
|---|--|---|
| <input type="checkbox"/> Fire Fighter | <input type="checkbox"/> Law Enforcement | <input type="checkbox"/> Social Services Worker |
| <input type="checkbox"/> Corrections Officer | <input type="checkbox"/> Security | <input type="checkbox"/> Emergency Management |
| <input type="checkbox"/> Mental Health Services | <input type="checkbox"/> None of these apply | <input type="checkbox"/> Other: _____ |

WORK HISTORY

Have you been or are you currently employed?

YES NO

What is /was the name of your most recent employer?

What is /was the employer's address?

What is /was the employer's city and state?

What is /was the employer's phone number?

What is/was your job title?

How many hours do/did you work per week?

Are/were you paid hourly or salary? Hourly

How often are/were you paid? Daily

How much were/are you earning each pay period? \$

When did you start working for this employer?

Are you still employed with this employer?

YES NO

• If no, when did your employment end with this employer?

• What was your reason for leaving?

• What were your job duties?

Were you employed prior to this position?

YES NO

What was the name of your previous employer?

What was the employer's address?

What was the employer's city and state?

What was the employer's phone number?

What was your job title?

How many hours did you work per week?

Were you paid hourly or salary?

Hourly

How often were you paid? Daily

How much were you earning each pay period? \$

When did you start working for this employer?

When did your employment end with this employer?

• What was your reason for leaving?

• What were your job duties?

CUSTOMER SIGNATURE:

DATE:

You have not been asked to provide your social security number on this form. For your information however, the Social Security Act (42 U.S.C. 1137) provides that your social security number may be used to administer the program, including determination of eligibility, attributing the receipt of services, correspondence and participation, as well as for reporting purposes.

An Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities.
All voice telephone numbers on this document may be reached by persons using TTY/TDD equipment via the Florida Relay Service at 711.
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