

Supplemental Nutrition Assistance Program (SNAP)

Employment and Training (E&T)

Interest and Skills Questionnaire

This questionnaire is a tool used by the Supplemental Nutrition Assistance Program (SNAP) Employment and Training (E&T). The SNAP E&T program staff will use the information you provide to help you develop a career path. The SNAP E&T program staff will also use this information to help you pick an activity to assist you in building the skills you need to help you move forward on your career path. Please print the information requested below.

Name: _____ Case Number: _____

Telephone Number: _____ Email Address: _____

Address: _____ City/State/Zip: _____

Mailing Address (if different): _____ City/State/Zip: _____

-
1. Please list the highest grade you completed below. If you received a diploma or degree, please list the degree, the school you attended and the year you completed your degree. _____

 2. Do you have a professional or technical certificate or license that is current? Yes No
If yes, please list all professional and technical certificates or licenses and the year you received your certification. (Examples include: CDL license, Certified Nursing Assistant – CNA, Certificate in Microsoft Office, etc.)

 3. Are you attending school now? Yes No
 - A. If yes, where are you going to school, what are you going to school for and how many hours of classes are you taking? _____

 - B. If no, would you like to go back to school? Yes No (*if no, skip to question 4*)
 - C. What would you like to go to school for? _____
 - D. What would make you drop out of school? _____
 4. Have you applied for or ever received financial assistance? Yes No
 5. Have you ever been enrolled in special education classes? Yes No
 6. Have you ever been tested for a learning disability? Yes No
 7. Do you have trouble working with numbers in columns? Yes No
 8. Do you have trouble remembering how to spell simple words? Yes No

9. Do you have trouble filling out forms? Yes No
10. Do you have trouble adding and subtracting small numbers in your head? Yes No
11. What language(s) do you speak? _____
12. Are you a Veteran? Yes No
- A. If yes, what skills did you receive in your military training? _____
- B. Are you the spouse or dependent of a military veteran? Yes No
13. Are you volunteering with a for-profit or not-for-profit employer in your community? Yes No If no, would you like to volunteer in your community? Yes No
14. What type of work would you like to do? _____
15. Are you currently looking for a job? Yes No
16. What type of job would you like to get in the next six months with your current skills? _____
17. Are you having difficulties finding work? Yes No
18. What do you think keeps you from getting or finding a job? _____
19. Are you re-entering the workforce after being a homemaker? Yes No
20. Did you lose your job because your skills were no longer in demand, your job went overseas, the business closed, or there was a layoff? Yes No
- A. If yes, describe the work you were doing? _____
- B. What city were you working in? _____
- C. What was the business name/employer? _____
21. Please check all of your skills and abilities:

<input type="checkbox"/> I type fast	<input type="checkbox"/> I can use the computer	<input type="checkbox"/> I can drive a truck or a bus	<input type="checkbox"/> I have worked in a warehouse	<input type="checkbox"/> I can answer multiple phone lines
<input type="checkbox"/> I have worked in an office	<input type="checkbox"/> I can file	<input type="checkbox"/> I can use a cash register	<input type="checkbox"/> I have worked in a restaurant cooking	<input type="checkbox"/> I have customer service skills
<input type="checkbox"/> I have worked in construction	<input type="checkbox"/> I have worked with kids	<input type="checkbox"/> I have worked in a medical office	<input type="checkbox"/> I have worked in a hotel.	<input type="checkbox"/> Other: _____

Work History Summary (List Most Recent Employer First)

1. Name of Employer _____ Job Title _____
Start Date _____ End Date _____ Full-time Part-time
Beginning Salary _____ Ending Salary _____ Hourly Weekly Other _____
What tasks did you perform at this job?

What did you like the most about this job? _____
What did you like the least? _____
Reason for leaving _____

2. Name of Employer _____ Job Title _____
Start Date _____ End Date _____ Full-time Part-time
Beginning Salary _____ Ending Salary _____ Hourly Weekly Other _____
What tasks did you perform at this job?

What tasks did you like the most? _____
What tasks did you like the least? _____
Reason for leaving _____

3. If you are working, did you report your employment to the Department of Children and Families? Yes
 No

Personal Summary

1. Do you have any medical, mental health or physical limitations that limit you in your work activity or training? Yes No If yes, explain: _____
2. Have any of the following issues ever caused a problem with you finding employment, keeping a job or keeping you from going to school?
A. Drugs **B.** Domestic Violence **C.** Depression **D.** Alcohol **E.** Other: _____

You can receive confidential services at any time. If you are a victim of domestic violence, you can disclose that you are dealing with domestic violence at any time. If you do not feel safe, there is a confidential hotline you can call as well. The number is 1-800-500-1119.

3. Are you currently involved in a treatment center or program (please describe)? _____

4. Do you have a criminal record and/or criminal conviction? Yes No

- 5. Did you go to jail? Yes No
- 6. Are you on probation or parole? Yes No
 - A. If yes, what are the terms of your release? _____
- 7. Are you currently going through a legal issue? Yes No
- 8. How do you plan to get to work or training activities? Bus Personal Vehicle Walk Bike
 Other _____
- 9. Do you need help paying for transportation? Yes No
- 10. Do you have a valid driver's license? Yes No
- 11. Do you have a place to live? Yes No If no, do you need assistance in finding a place to live?
Yes No If yes, please explain: _____
- 12. Have you applied for Unemployment Compensation? Yes No If yes, when? _____
- 13. Are you pregnant or a parent (and your children live with you)? Yes No
- 14. Are you a foster child or in the foster care system? Yes No

Volunteer's Signature

Program Staff's Signature

Date

Date

Comments: (OFFICIAL USE ONLY)
