

Initial Assessment

Name: _____ Last Four SSN: _____ Date: _____/_____/20

Home Phone Number: _____ Cell Number: _____

Emergency Contact Name: _____ Emergency Contact Number: _____

Other Contact Number: _____ Contact Type: _____

Address _____

Street

City

State

Zip

Children in the Household

Age

_____	_____	In school? <input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	In school? <input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	In school? <input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	In school? <input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	In school? <input type="checkbox"/> Yes	<input type="checkbox"/> No

How can we help you right now?

- I want a job so I can pay the bills
- I want to go to school so I can get a better job
- I want childcare so I can get a job or go to school
- I want childcare for medical appointments
- I want help with transportation so I can get a job or go to school
- I want help with transportation so I can get to doctor's appointments and/or therapy appointments
- I could use an advocate dealing with my doctor
- I want help applying for social security
- Other _____

What do you feel are your most pressing needs?

- I need to pay my light or utility bill
- I need help with rent or I may become homeless
- I need to set up childcare
- I have a lot of past due bills that are causing problems
- I have to go to court
- I have to complete community service
- I have to meet with my probation officer and that takes a lot of my time
- I have fines that I have to pay to get my license back or begin working again
- I have a felony charge that I feel keeps me from getting a job
- I do not feel safe when I go home
- I have no way to get around town
- I do not feel safe with my partner
- I feel alone and overwhelmed, I would like someone to help me
- I want help finding a job
- I want help getting back in to school

Welcome to our program. We want to provide you with services so you can begin moving towards a career you will enjoy and be rewarding.

Our program is designed to help you gain skills you need to start a career you want. What kind of career are you interested in?

- Nursing
- Accounting

- | | |
|---|---|
| <input type="checkbox"/> Teaching | <input type="checkbox"/> Childcare |
| <input type="checkbox"/> X-Ray Technology | <input type="checkbox"/> Massage or Physical Therapy |
| <input type="checkbox"/> Pharmacy | <input type="checkbox"/> Food Service |
| <input type="checkbox"/> Hospitality | <input type="checkbox"/> Carpentry, Welding |
| <input type="checkbox"/> Clerical | <input type="checkbox"/> Driving trucks, buses or taxis |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Computers/Technology |
| <input type="checkbox"/> Policy/Detective | <input type="checkbox"/> Firefighter |
| <input type="checkbox"/> Phlebotomist | <input type="checkbox"/> Other medical |
| <input type="checkbox"/> I am not really sure | <input type="checkbox"/> Other _____ |

Do you have a high school diploma or GED? Yes No If no, highest grade completed: _____

Have you ever obtained a certificate for gaining skills on the job or in training? Yes No
What was the skill or the training called? _____

Did you enjoy going to school? Yes No
What did you like about school? _____
What did you dislike about school? _____

Were you ever tested for a learning disability? Yes No

If you could go back to school, what type of education or training would you want to enter?

- | | |
|--|---|
| <input type="checkbox"/> GED | <input type="checkbox"/> Diploma |
| <input type="checkbox"/> College | <input type="checkbox"/> Clerical (answering phones, typing, medical assistant) |
| <input type="checkbox"/> Patient Care/Nursing Certificate | <input type="checkbox"/> Computers |
| <input type="checkbox"/> Childcare or Substitute Teaching | <input type="checkbox"/> Truck Driving |
| <input type="checkbox"/> Dental Assistant | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> I am not interested in going back to school | |

Have you applied to go back to school within the last three months? Yes No
If yes, where? _____ For what? _____

Are there circumstances that would prevent you from going to work, going to school or other activities?
 Yes No If yes, Please describe _____

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- a. Do you have someone to watch your children everyday while you are at work and school?
 Yes No
- b. Would you like childcare so you can go to work and/or school everyday? Yes No
- c. If your children are sick, who will take care of your children while you go to work or school?

- d. Do you have to leave work, school or home to deal with your child's behavior problems on a regular basis? Yes No If yes, is your child seeing a counselor regularly? Yes No
- e. Do you have to leave work, school or home to deal with your child's health issue on a regular basis?
 Yes No If yes, who will be able to help you while you are working with us? _____
- f. How will you get to school or work everyday? Bus Own car A ride with friend or family member Walk Taxi
- g. Would you like help paying for transportation? Yes No

Do you know what steps you need to take to start your career?

Yes No If yes, please enter what steps you need to take to start this career: _____

Work history provides a lot of great information to help you prepare for work or school. Please take time to complete the following section of the form

Employer	Phone	Job Title
Employer Address	City, State	Wage (annual or per hour)
No. of Hours Per Week	Start Date/End Date	Reason for Leaving
Job Duties		

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What are other skills that you have? Examples include: caring for children, answering multi-line phones, typing 30 wpm, etc.

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Participant Signature: _____ **Date:** _____

Case Manager Signature: _____ Reviewed with customer on: _____

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