

OBJECTIVE ASSESSMENT

DATE: ___/___/___

Are you completing this with a current TANF participant? Yes No RESCREEN DATE(S): _____

Participant Information

Name: _____ Phone Number: _____

Primary Language spoken: _____

Physical address: _____

Mailing address: _____

Email: _____

Emergency Contact Name: _____ Phone Number: _____

Internet Access

Do you have a working smart phone? Yes No Unlimited data? Yes No

Cell Phone Provider: _____ Pay as you go or monthly plan? _____

Do you have reliable access to Wi-Fi? Yes No Wi-Fi Provider: _____

Do you have a computer, laptop, or tablet with audio and video capabilities to meet virtually? Yes No

What made you decide to seek services?

What goals do you hope to achieve while working with us? Have you already taken any steps toward those goals? What worked and what didn't?

Education

High School Diploma or GED received from: _____ Year: _____

If not completed, what was your last grade completed?

Grade: _____ Year Completed: _____ School: _____

Are you currently attending high school or participating in a GED or literacy program? Yes No

If yes, where? _____

Are you interested in obtaining your diploma or GED? Yes No NA

If yes, what is preventing you from pursuing your diploma or GED? _____

If yes, what help could you use to get your diploma or GED? _____

Do you have any education beyond high school? (i.e. college, vocational school, training certificates) Yes No

If yes, what did you study?

If yes, did you earn a credential such as a diploma, certificate, degree, doctorate, etc.?

Do you wish to explore furthering your education? Yes No

If yes, what field of study are you interested in pursuing?

Circle what applies:

- Needs interpretation services
- Currently enrolled in ABE/Literacy or ESL
- Behind grade level for age (Youth only)
- Non-reader
- Lacks computer skills
- Needs to apply for financial aid (FAFSA)
- Awarded/currently receiving financial aid
- Awarded/currently receiving Pell Grants
- Awarded/currently receiving Monetary Award Program (MAP) Grant

Justice System Involvement

Are you, or have you ever been, involved with the justice system? Yes No

If **yes**, what is your current status:

- None
- Incarcerated
- On probation
- On parole
- Under supervision
- Work release program
- Halfway house
- On aftercare
- House arrest/home confinement
- Formerly incarcerated and not on parole

Conviction type(s): Misdemeanor Felony Unsure Other

Conviction Date: ___/___/___ Discharge Date: ___/___/___

Other legal issues:

- Existing/pending workers compensation claim
- Court ordered to pay child support
- Wage garnishment

If on probation/parole/aftercare, who is your Probation Officer/Parole Agent/JCA? What requirements do you have with this agency?

Do you have any outstanding warrants, citations, pending charges, or court dates scheduled? Yes No

If **yes**, please explain:

Workplace Readiness

Have motivational factors affected employment:

- Negative attitude
- Punctuality issues
- Coworker relation issues
- Issues making clear decisions
- No clearly defined goals
- Other:

Do any of these apply:

- Obsolete work skills
- Union dues in arrears
- Occupational license expired/revoked

Access Assessment

Are any of these tasks difficult to perform independently:

- None
- Seeing
- Hearing
- Talking
- Using hands
- Getting around
- Interacting with others
- Learning or thinking

Are any of these items needed to pursue training or employment:

- None
- Assistance with writing
- Personal coaching
- Scent free environment
- Note takers for regular meetings
- Wheelchair accessible facilities

When completing applications, do you need:

- Assistance with thoroughness
- assistance with neatness
- help addressing sensitive issues
- assistance with summarizing skills or work history

Considering your interviewing skills, do you have any areas of improvement? (check all that apply):

- Making a positive first impression
- Needs help developing questions for interviewer
- Focusing on a positive attitude
- May benefit from a mock interview or FAQ answers
- Needs proper interview attire
- Difficulty explaining work experience and skills
- Communication skills
- Needs help researching Labor Market Information (LMI)

Check your individual strengths and/or experience:

Punctual	Clerical experience	Motivated
Problem solving	Enjoys helping others	Enjoys working with kids
Dependable	Hard worker	Cleaning
Organizing	Budgeting skills	Cooking
Supervisory experience	Proficient typing skills	Enjoys working with animals
Academics	Building things	Quick learner
Working on cars	Good with animals	Working on/with computers
Good listener	Mechanical experience	Creative
Positive attitude	Enjoys reading	Self-starter
Management experience	Manages household well	Flexible
Handle stress well	Support from family and/or friends	Energetic
Cultural Awareness	Enthusiastic	Ask questions
Strong work ethic	Good role model	Self-confident
Not judgmental	Bilingual	Risk taker
Able to make decisions	Know community resources	Loyal
Good time management	Follow directions well	Honest
Can express myself in writing	Leadership skills	Positive attitude
Good parenting skills	Good appearance and hygiene	Get along with others
Able to speak in public	Regular work attendance	Understanding/Empathy

Transportation

Do you have a valid driver's license? Yes No

If **yes**, do you have a CDL? Yes No

If **yes**, do you have any endorsements?:

- Two or three-wheeled motorcycle
- School bus
- Double and triple trailers
- Private vehicle class
- City government vehicles
- Combination hazardous materials and tanker
- Passenger vehicles
- Tankers

If **no**, what is preventing you from obtaining your driver's license?

Suspended Restrictions Other: _____

Do you have a vehicle available to use? Yes No

If **yes**:

Is it reliable? Yes No Is it in need of repairs? Yes No Is it currently insured? Yes No

Who is it registered to? _____ If not you, relationship to owner: _____

If **no**, How do you travel for daily activities? _____

Is this form of transportation reliable? Yes No

If no, how would you travel to work or work activity?:

Financial Situation & Resources

Do you have any concerns regarding your credit/financial situation?

Select all that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> Interested in money management services | <input type="checkbox"/> Poor credit history | <input type="checkbox"/> Bankruptcy |
| <input type="checkbox"/> Interested in consumer credit counseling services | <input type="checkbox"/> Defaulted student loan | <input type="checkbox"/> Inability to be bonded |
| <input type="checkbox"/> Inability to pay bills, rent/mortgage | <input type="checkbox"/> Credit card debt | <input type="checkbox"/> No Financial Resources |
| <input type="checkbox"/> Other: | | |

Have you utilized any of the following resources in the last 6 months, select all that apply.:

- | | | |
|---|---|---|
| <input type="checkbox"/> DLR Services | <input type="checkbox"/> Local/County Assistance Programs | <input type="checkbox"/> Migrant Seasonal Farm Worker Program |
| <input type="checkbox"/> Job Corps | <input type="checkbox"/> Vocational Rehabilitation | <input type="checkbox"/> Community Services Block Grant |
| <input type="checkbox"/> Foster Care | <input type="checkbox"/> Native American Programs | <input type="checkbox"/> Senior Workers (SCSEP) |
| <input type="checkbox"/> Veteran Services | <input type="checkbox"/> Trade Adjustment Assistance (TAA) | <input type="checkbox"/> Housing and Urban Development (HUD) |
| <input type="checkbox"/> Supplemental Nutrition Assistance Program (SNAP) | <input type="checkbox"/> Temporary Assistance for Needy Families (TANF) | <input type="checkbox"/> Social Security Administration |

Healthcare Needs

Do you have access to medical insurance or Medicaid? Yes No

Adult Health Care

Do you have any concerns regarding medical conditions or a disability that makes it difficult for you to obtain and/or keep a job? Yes No

(If no, skip to next section)

If yes, please explain:

Are you currently under a doctor's care or receiving treatment for this condition? Yes No

Have you applied for or are you receiving Social Security Benefits (SSI/SSDI)? Yes No

If you have applied for benefits, who (if anyone) is assisting you with your application? _____

Pregnancy

Are you or anyone in your household currently pregnant? Yes No **(If no, skip to next section)**

What is the due date?

Is the pregnant person receiving regular prenatal care? Yes No If no, please explain:

Are there any health concerns related to the pregnancy? Yes No If yes, please describe

Adult Mental Health

Do you have concerns regarding mental or emotional health that makes it hard to get and/or keep a job? Yes No

(Examples: anxiety, depression, trauma/PTSD, grief/loss, abusive relationships, physical/emotional abuse, etc.)

(If no, skip to the "Substance Use" section)

Describe how this impacts your daily living activities. (Examples: lack of or excessive appetite, everything is an effort, lonely, people dislike me, people are unfriendly, I'm unhappy/sad, poor sleep, etc.)

What does your daily routine look like regarding managing your mental/emotional health? (Examples: date symptoms started, triggers, treatment plan, expected duration, etc.)

Explain what you are currently doing to address these concerns: (Examples: medication, seeing a counselor, group meetings, etc.)

While keeping your current mental/emotional health in mind, describe what type of work you can do:

Substance Use

In the last 6 months, has drug or alcohol use negatively impacted you or your family? Yes No

(Examples: job loss, school dropout, failed relationships, attendance issues, etc.)

Have you been convicted of any alcohol and/or drug related charges? (Examples: DUI, possession, etc.) Yes No

If yes, please explain:

(If no to questions above, skip to next section.)

Have you participated in any alcohol and/or substance use treatment programs? Yes No

If yes: What program? _____ Where? _____ When? _____

Did you successfully complete the program? Yes No

If no, please explain:

Did you follow through with any discharge recommendations? (Example: Aftercare, group, etc.) Yes No

If yes, please describe:

Have you attended any self-help organizations such as AA/NA/GA or any other services to help you stop using alcohol and/or substances? Yes No

If yes please describe: (Where, when, what programs, services, etc.)

If no, what services or programs interest you that can support your path to alcohol and/or substance free living?

Children

Do you have any children in your home? Yes No **(If no, skip to “Living and Family Environment” section)**

List children in your home, their age, school, and/or childcare provider as applicable:

Child Name	Age	School	Childcare Provider

School aged children

Do you have children attending school? Yes No **(If no, skip this section)**

Do you have after school care for your children? Yes No

Do you have summer care for your children? Yes No

If yes, who is your summer childcare provider?

Child Health

Do you have a child(ren) who requires specialized care? Yes No **(If no, skip to next page)**

If yes, please describe your child(ren)’s daily routine and care requirements:

If yes, have you located a child care provider that meets your child’s specific needs? Yes No

If yes, who?

Living and Family Environment

Household Composition – Who do you live with? (You do not need to list children listed in previous section):

Name	Relationship	Contact Phone and/or Email

*Note: If a phone/email is provided is this person listed on Form 1 and/or is this an alternate form of contact for the participant?

Do you have stable housing? Yes No

Do any of the following apply to your housing situation?

- | | |
|--|---|
| <input type="checkbox"/> Homeless | <input type="checkbox"/> Living in substandard conditions |
| <input type="checkbox"/> At risk of being homeless | <input type="checkbox"/> In need of energy assistance |
| <input type="checkbox"/> Facing possible eviction | <input type="checkbox"/> Residing in public housing |
| <input type="checkbox"/> Residing in shelter | <input type="checkbox"/> Living with family |
| <input type="checkbox"/> Living alone | <input type="checkbox"/> In need of food at home |
| <input type="checkbox"/> Receiving housing assistance | <input type="checkbox"/> Have any outstanding issues with a housing authority |
| <input type="checkbox"/> Past due on rent or utilities | <input type="checkbox"/> Other: |

Do you have any concerns with household members such as alcohol and/or substance use, mental health, lack of support, fighting, breaking the law, etc.? Yes No

If **yes**, please explain:

Family Safety

In the past year, have you experienced any domestic or family violence? Yes No

If yes, please explain:

Have you asked anyone for help? Yes No If yes, who? _____

Do you have any safety concerns for you or your family? Yes No

Do you need immediate help to remove yourself from a domestic situation? Yes No

Do you need to keep your address a secret? Yes No

 If yes, do you have a safety plan? Yes No

 If no, do you need help developing a safety plan? Yes No

Have you filed for a protection order? Yes No

 If yes, where did you file and who did you file against? _____

Are you currently residing in a domestic violence shelter? Yes No

 If yes, where?

 If yes, who is your advocate?

How has this situation affected you and your family?

Notes: