

FAMILY SELF SUFFICIENCY ASSESSMENT

(Please print all information)

CCS CLIENT #:

General information:

Name: _____ Male/Female DOB: _____ SSN: _____

Address: _____ Zip: _____ Complex: _____

Phone: home: _____ work: _____ cell/pager: _____ email: _____

Emergency contact: _____ phone: _____ relationship: _____

Section 8 housing subsidy: ___certificate or ___voucher or Public Housing___ PH Lease #:

Property Manager: _____ Resident Counselor: _____

Race:

___Asian/Pacific Islander ___African American ___Hispanic
___Native American/Alaskan native ___Caucasian ___Other _____

Citizenship status: ___U. S. Citizen ___Resident Alien ___Student/Work Visa ___Green Card

Country of origin: _____

Marital status:

___Married ___Separated ___Divorced ___Widowed ___Never married

Other adults in the home (18 or older):

Name	Relationship	DOB	Work/School status

Participant's Career goal (if known): _____

Participant's need for special accommodations? _____

Self-Sufficiency Index for Child Development/Child Care*

Name:	DOB:	Age:	School:	Grade:
Strengths/Interests/Activities:				
Social, behavioral, academic concerns; special needs; disabilities:				
Name:	DOB:	Age:	School:	Grade:
Strengths/Interests/Activities:				
Social, behavioral, academic concerns; special needs; disabilities:				
Name:	DOB:	Age:	School:	Grade:
Strengths/Interests/Activities:				
Social, behavioral, academic concerns; special needs; disabilities:				
Name:	DOB:	Age:	School:	Grade:
Strengths/Interests/Activities:				
Social, behavioral, academic concerns; special needs; disabilities:				
Name:	DOB:	Age:	School:	Grade:
Strengths/Interests/Activities:				
Social, behavioral, academic concerns; special needs; disabilities:				

* Note relationship, if not your child.

Child Care Information:

Child's Name	Name & Address of Provider	Center, Family Provider, Other	Licensed Y/N	Phone	Hours in Daycare	POC/WPA & Amount Received

How often do you talk with the daycare provider about your child(ren)'s behavior? _____

Will you need day care assistance if you attend school/training or become employed? ____ Yes ____ No

Who will be the provider? _____, a relative/friend/neighbor/other. ____ Licensed?

School:

How often do you talk with your child(ren)'s teacher(s) counselor(s)? _____

If your child(ren) dislike school in general, why? _____

What has been your response to the situation? _____

Parent/Child Relationship:

Describe two ways you show your child(ren) you care:

1) _____ 2) _____

Describe two ways you show your child(ren) you are displeased with his/her/their behavior:

1) _____ 2) _____

Are these means effective? ____ Yes ____ No ____ Somewhat: _____

Would you like to learn additional child-rearing techniques? ____ Yes ____ No

Would any of your children be interested in:

____ Job skills training: _____ What skills do they have? _____

____ Employment: ____ FT ____ PT ____ Summer ____ Big Brother/Sister ____ Summer camp

Absent Parent(s):

How often do(es) absent parents(s) visit/call your child(ren)? _____

Do(es) absent parent(s) pay child support? _____

Other assistance? _____

Self-Sufficiency Index for Transportation

What transportation do you use to get you where you need to go?

Do you have a valid driver's license? ____ Yes ____ No. Do you own an operational car? ____ No ____ Yes

Car make, model, year & condition

Car payment per month \$ _____ Gas per month \$ _____ Other costs \$ _____

Do you have insurance coverage? ____ Yes ____ No Cost: \$ _____ per month/quarter/year

Can you walk to public transportation from home? ____ Yes ____ No: _____

Can you get to/from work by public transportation? ____ Yes ____ No: _____

Are you able to pay for bus flashpass/metro farecard? ___ Yes ___ No Cost? \$ _____ /wk \$ _____ mo.

If you can't afford it, do you need to use public transportation: ___ 1-3 days/week ___ 4+ days/week?

What transportation needs do you have? _____

Self Sufficiency Index for Financial Independence

What is your family's total annual income? \$ _____ Monthly? \$ _____

How much is earned through employment? Annual gross \$ _____ Monthly net \$ _____

How much of this income is unearned and from what sources? (see below)

Sources	Monthly Amt.	Sources	Monthly Amt.
Unemployment		SSDI (for _____)	
Child Support/Alimony		WIC	
Food Stamps		Work-Study	
TCA		Educational Scholarships	
Social Security (for _____)		Other (_____)	
SSI (for _____)			

Did you receive the Earned Income Tax Credit (EITC)? ___ Yes ___ No

Are you receiving:

Medical Assistance? ___ family ___ children only; CHIP? ___ children

Other Health Ins.? Company _____; ___ family ___ children only ___ participant only

What do you pay for childcare? \$ _____ /week \$ _____ /month

Have you ever applied for child support? ___ Yes ___ No Status: _____

Questions re debts	Yes/No	Repaymt signed?	Amt.Owed or Paymts.	Reason
Do you owe a damage claim?				
Are your payments current?				
Do you owe a security deposit loan?				
Are your payments current?				
Other debts to HOC:				

Have you ever filed bankruptcy? ___ Pending ___ No ___ Yes Date: _____

Do you have any court judgments against you? ___ No ___ Yes: _____

Do you have a checking account? ___ Yes ___ No Savings account? ___ Yes ___ No

Do you buy mostly with: ____ credit? or ____ cash?

Do you often run out of money? ____ Yes ____ No What do you do when this happens? _____

Do you work by a budget? ____ Yes ____ No If not, would you like to learn to set up a budget with money management or financial counseling? ____ Yes ____ No Describe your credit status: _____

Outstanding debts that need to be paid		
Credit Cards:	Amount	Repayment Plan
Educational Loans:	Amount	Repayment Plan
Other:	Amount	Repayment Plan

Monthly Budget		
Bills	Amount \$	Are you current?
Rent		
Electric		
Gas		
Water		
Phone		
Cable		
Credit Cards		
Car/Other trans.		
Food		
Clothing		
Childcare		
Total Bills	\$	
Total Net Income	\$	

Self Sufficiency Index for School/ Training/Employment

What is your primary language? _____ Do you read & write in your language? __ Yes __ No

Who in your family needs to improve English language skills? _____

Who needs an interpreter? _____

Is any family member a veteran of the Armed Forces? ____ No ____ Yes: _____

What skills/training do you have? _____

What skills/training do you want? _____.

____ Unsure

What do you want most out of life? _____

What do you want to accomplish for your career development in the next year? _____

In the next 5 years? _____

Highest grade completed in school: less than 6 - 6 - 7 - 8 - 9 - 10 - 11 (*circle one*)

	Degree, Field or Program	Enrolled Now?	Year complete(d)	College/ School
High school				
GED				
English language				
Some college				
Completed Associate (AA) or certif. Program				
College degree (BA, BS)				
Other training				

List any barriers/needs preventing employment for you/any family members:

Transportation Health School materials Calendar
 Childcare Alarm clock Clothes Other: _____

Describe your current job and two previous jobs:

Current Employer:	Job Duties:	Reason left:
Job Title:		
Dates Employed: _____ to _____		
Previous Employer:	Job Duties:	Reason left:
Job Title:		
Dates Employed: _____ to _____		
Previous Employer:	Job Duties:	Reason left:
Job Title:		
Dates Employed: _____ to _____		

Do you know what job you would like? Unsure Yes If so, what would it be?

[For someone employed, ask re stability]

Will your job probably continue? Yes No Unsure

What changes would you like in your job? _____

Would you like training to upgrade skills? No Yes: _____

Would you like a support group to help you cope with job stress/ relationships? _____

How do you get along with your supervisor? _____

How many days have you missed from work in the past 6 months? _____

Why? _____

[For someone unemployed, ask re job search, school/ training]

Do you have a current resume? ___ Yes ___ No If not, would you like help? ___ Yes ___ No

How often do you look for work? _____ Where? _____

What kind of help do you need with your job search? ___ Job Club ___ Pre-employment training

___ A mentor/ job coach/ on-the-job training ___ Volunteer work site experience

Are you involved with HOC's Employment Initiative Program? ___ Yes ___ No

If so, what program? ___ Employment Support Group

___ Classes: _____

___ Volunteer work experience at _____

___ Other: _____

Do you have a disability? ___ No ___ Yes: _____

Do you need: ___ To learn how to read ___ To learn how to write better

___ Tutoring in _____

[For someone in school, stability]

What are your long-term career goals/ plans? _____

How do you pay for schooling? _____

What school/training debts do you have? _____

How many days have you missed from school/training in the past 6 months and why?

Self-Sufficiency Index for Health & Mental Health

Where do you take your child(ren) for medical care and how often? _____

How do you decide when you/your child(ren) should be seen by a doctor? _____

When was the last time:

You were seen by a doctor and why? _____

Your child(ren) were seen by a doctor and why? _____

You/your child(ren) went to the Emergency Room & why? _____

You had a dental check-up? _____

Your child(ren) had a dental check-up? _____

What medication(s) are you/your child(ren) taking? _____

Are there any medications you/your child(ren) should be taking but or not?

How many days have your child(ren) missed from school in the past 6 months and why? _____

Does your/your child(ren)'s health interfere with your daily routine, work or school? ____ No
 ____ Yes: _____

Mental Health & Medical Services* needed by any family member

Name	Problem	Treatment /Provider	Currently in Treatment?	Treatment Needed?

*include physical health, dental, vision, hearing, therapy, hospitalization, residential treatment, juvenile programs, individual/teen/family/marriage counseling, etc.

In the past 6 months:

Has your appetite changed? ____ Yes ____ No Do you feel tired most of the time? ____ Yes ____ No
 Any difficulty sleeping at night? ____ Yes ____ No How long do you usually nap during the day? _____
 Would you like help with ____ weight loss ____ exercise ____ family planning services?

Do you have any concerns about your family's nutritional health? ____ No ____ Yes: _____
 Would you like a program for ____ nutritional counseling? ____ weight loss?

History of illegal drugs or alcohol by you or any family member?

Name	Drug/Alcohol Used	When	Treatment	Recovery Plan

Describe any history of child/spouse/sexual abuse or domestic violence that you or any family member has experienced: _____

Have you ever been charged with child neglect/abuse? ____ No ____ Yes: _____

Have you ever been charged with any criminal offense? ____ No ____ Yes: _____

When you feel overwhelmed, what do you do? _____

What are you most concerned about now? _____

Self-Sufficiency Index for Support Systems

What holds your family together and keeps it going? _____

What recreational activities do you do with your children? _____

What do you like to do when you are not in school or working?

How often do you get together with friends, neighbors, relatives for leisure time? _____

What do you like to do with other people? _____

Who provides your support system--parents, other relatives, friends, neighbors, church?

Are there any family interrelationships and/or issues you feel need improvement?

What community organizations or groups are you involved with (church/synagogue, neighborhood group, Scouts, etc.) & what help do you receive? _____

What service agencies have you received help from in the past?

____ Dept. of Health and Human Services: _____

____ Mental Health Association: _____

____ Department of Family Resources: _____

____ Commission for Women: _____

____ Legal Aid: _____

____ Health Dept./Clinics: _____

____ Other: _____

What social service agencies do you receive help from now?

Describe any problems with your housing (unsafe, rodents, etc.)? _____

Do you need help with household repairs? ___ No ___ Yes: _____

Managing housekeeping chores? ___ Yes ___ No

Have you received complaints by your landlord/neighbors in the past year about:

___ housekeeping? ___ children's behavior? ___ damages? _____

Do you have any other concerns we haven't discussed? _____

Signatures:

Head of Household

Date: _____

Case Manager

Date: _____