

## KENTUCKY WORKS PROGRAM ASSESSMENT [FORM]

Participant Name \_\_\_\_\_

Participant SSN \_\_\_\_\_

### EMPLOYMENT

Are you working now?  Yes  No

Who were your last 3 employers?

Employer	How long	Job Title/Duties

In your past work experience, what did you like about your jobs?

What did you dislike?

In your previous jobs, how often did you miss work?

What caused you to miss work?

Have you done anything to earn extra money?  Yes  No If yes, explain:

Have you worked without pay to help at church, your child's school or in the community?

Yes  No

If yes, explain:

Do you have any specific skills like computer or cashier skills?  Yes  No If yes, describe:

What kind of work would you like [~~do you want~~] to do?

Are there any reasons you cannot look for work or accept a job?  Yes  No If yes, explain:

Do you have any felonies or misdemeanors that would show on an employer's background check?

Yes  No If yes, list convictions, dates, and places:

Do you have any pending charges?  Yes  No If yes, list charges, dates, and places:

*Worker Observations/Additional Comments (Do not ask the participant the following questions.)*

*Did the participant talk about past work experience that is important to note?*

*Did the participant indicate any training is needed?*

## EDUCATION

Is English your first language?  Yes  No If no, do you need ESL Classes?  Yes  No

Do you have a high school diploma or GED?  Yes  No If no, what was the highest grade you completed?

Have you considered getting a GED or furthering your education?  Yes  No If yes, to go to school, what steps do you need to take?

How many hours of postsecondary school (college or vocational) do you have?

Do you have any degrees or certificates?  Yes  No If Yes, what?

*Worker Observations/Additional Comments*

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## BARRIERS

Who will be your child care provider while you are participating in KWP?

What is your back-up plan when your child is sick and unable to go to daycare?

Who watches your children when you run errands, have doctor visits, etc.?

Do you own a vehicle?  Yes  No Is it licensed?  Yes  No

Do you have car insurance?  Yes  No

Do you have a current driver's license?  Yes  No If not, why not?

What other means of transportation do you have?

Is your present housing situation stable?  Yes  No

How many times have you moved in the last 12 months? Why?

How do you pay for personal care items like shampoo, toothpaste, and soap?

Do you have appropriate clothing for job interviews or for your day-to-day employment?  
 Yes  No

Do you have a phone?  Yes  No If no, do you have a way to receive messages?  
 Yes  No

How may we contact you?

Do you need glasses or dental care (dentures, etc.)?  Yes  No If yes, what is needed?

Does someone not want you to work, go to school/training, or participate in our programs?

Yes  No

If yes, who? How might he or she act if you do?

Are you afraid for your own or your children's safety?  Yes  No If yes, explain:

Has a friend or loved one hurt you by calling you names, putting you down, telling you that you are no good, stupid, etc.?  Yes  No If yes, explain:

Has a friend or loved one physically hurt you (hit, kicked, shoved, grabbed) or threatened to physically hurt you?  Yes  No If yes, explain:

Have you filed for an Emergency Protection Order (EPO) or Domestic Violence Order (DVO) against a family member or significant other?  Yes  No

If yes, what charges were filed? Who were the charges filed against [øø]?

When? Where (city, county)?

What is his/her relationship to you?

Are any of your children having problems with defiant behavior, school attendance, or have they had legal problems?  Yes  No If yes, who?

If so, what is the problem?

Has anyone in your household been in trouble because of drugs or alcohol?  Yes  No If yes, explain: [?]

Are other agencies helping you?  Yes  No If yes, who?

*Worker Observations/Additional Comments (Do not ask the participant the following questions.)*

*Does the participant mention other barriers that are not addressed?*

*Does the participant appear to be abused mentally or physically?*

Do you agree to be screened for a physical disability assessment?  Yes  No

## **GENERAL HEALTH**

Within the past year have you been under a doctor's care?  Yes  No If yes, explain:

Within the past year have you received medical treatment such as Physical Therapy, Occupational Therapy, or Speech Language therapy?  Yes  No If yes, explain:

Are you currently take any medications?  Yes  No If yes, for what?

Has the doctor told you not to do certain kinds of work?  Yes  No If yes, what?

Is there anything about your health that presents a challenge to your working or participating in work activities?  Yes  No If yes, explain:

Do you have any concerns about the health of any of your family members that would make it hard for you to get or keep a job?  Yes  No If yes, explain.

Do you have someone in your home for whom only you can provide care?  Yes  No If yes, who and why?

Do you have a child or family member with special needs?  Yes  No If yes, who?

*Worker Observations/Additional Comments*

*Enter any observations not addressed in other sections.  
Enter any needed referrals.*

Do you agree to be screened for a mental health assessment?  Yes  No

**MENTAL HEALTH**

Within in the past year have you been involved in counseling, therapy, recovery (e.g. AA/NA, community mental health center, etc.)?

Yes  No If yes, explain:

Within the past year have you been diagnosed as being depressed or having any other mental health condition?

Yes  No If yes, describe:

Within the past year have you had any trouble doing the things you need to do every day because you felt hopeless, blue, or sad?  Yes  No If yes, explain:

Within the past year have you felt extremely tense, anxious, worried, or felt your "nerves" were so bad that you haven't been able to do the things you need to do?  Yes  No If yes, explain:

Do you believe you have trouble paying attention, staying interested?  Yes  No

Within the past year have you felt you wanted to harm yourself or others?  Yes  No If yes, explain:

Within the past year have you used alcohol or drugs to feel better?  Yes  No If yes, explain:

Within the past year have you worried you weren't keeping up with everything you needed to do because of your use of alcohol or drugs?  Yes  No If yes, explain:

Within the past year have you felt angry because someone criticized your use of alcohol or other drugs?  Yes  No If yes, explain:

Have you been in trouble because of drugs or alcohol?  Yes  No If yes, explain:

*Worker Observations/Additional Comments (Do not ask the participant the following questions.)  
Does the participant appear to have any unusual physical movements?*

*Does the participant seem to have hallucinations or delusions?  
Does the participant appear to have physical signs of substance abuse?  
Enter any needed referrals*

Do you agree to be screened for a Learning Needs assessment?  Yes  No

### **LEARNING NEEDS**

Have you ever been diagnosed with a learning disability?  Yes  No If yes, what was the diagnosis?

Did you have any problems learning in middle school or junior high?  Yes  No (Section A)

Do you have difficulty working from a test booklet to an answer sheet?  Yes  No (Section A)

Do you have difficulty or experience problems working with numbers in a column?  Yes  No (Section A)

Do you have trouble judging distances?  Yes  No (Section A)

Do any family members have learning problems?  Yes  No (Section A)

Did you have any problems learning in elementary school?  Yes  No (Section B)

Do you have difficulty or experience problems missing mathematical signs (+/X)?  Yes  No (Section B)

Do you have difficulty or experience problems filling out forms?  Yes  No (Section C)

Do you experience difficulty memorizing numbers?  Yes  No (Section C)

Do you have difficulty remembering how to spell simple words you know?  Yes  No (Section C)

Do you have difficulty or experience problems taking notes?  Yes  No (Section D)

Do you have difficulty or experience problems adding and subtracting small numbers in your head?  Yes  No (Section D)

Were you ever in a special program or given extra help in school?  Yes  No (Section D)

*Worker Observations/Additional Comments (Do not ask the participant the following questions.)*

*Does the participant seem to have difficulty following directions, understanding questions, reading, or writing English, etc.?*