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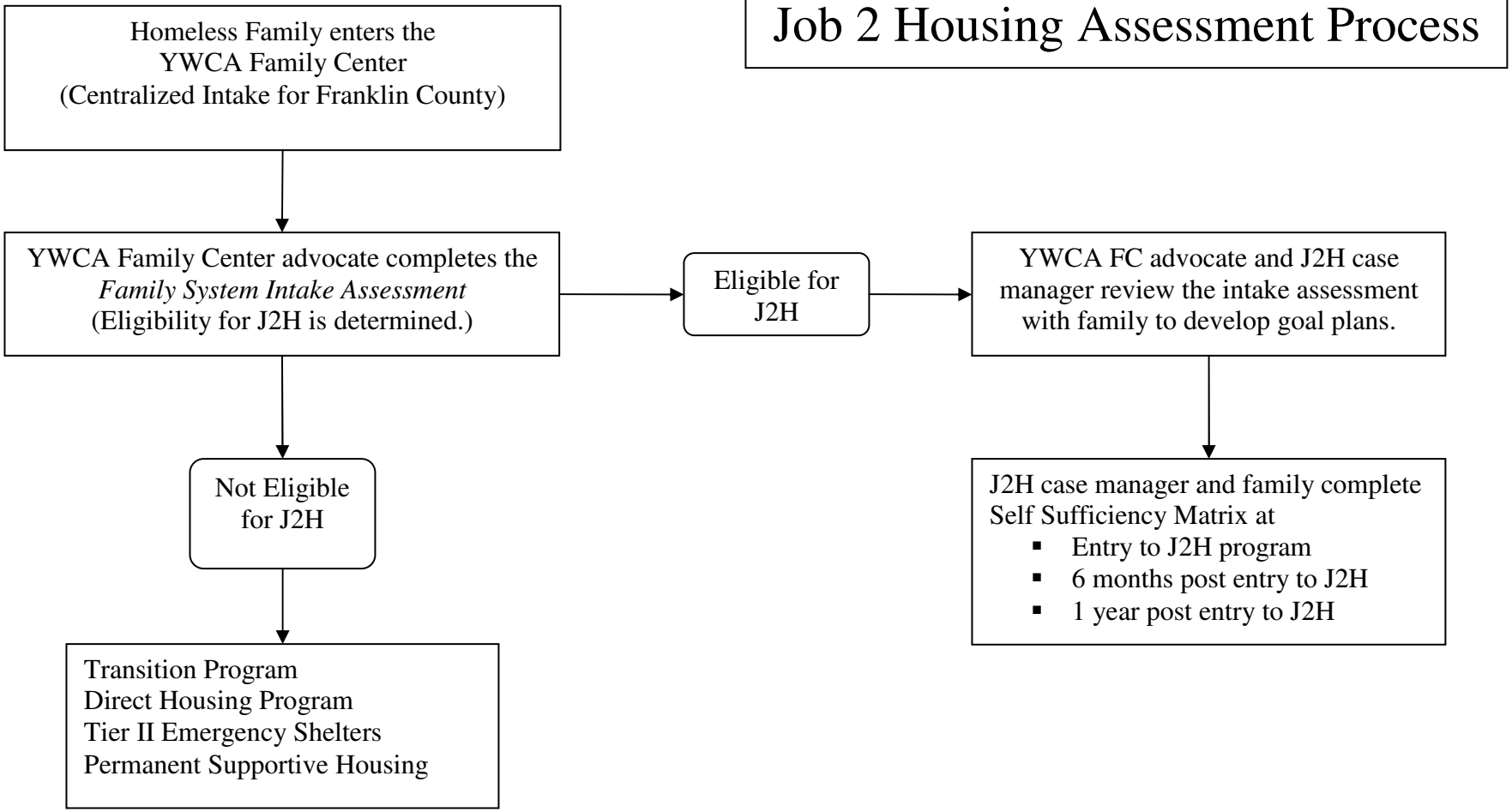
Job 2 Housing Assessment Process



HOH Initials: _____

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FAMILY SYSTEM INTAKE ASSESSMENT

(FOR INTAKE SUPERVISOR ONLY: Intake Audit Complete☐ Date: _____ Staff Initial: _____)

Intake Date: ____ Time: ____ Intake Staff:_____ Translator needed? ☐Y ☐ N Language? _____

Will family be driving? ☐Y ☐N Vehicle make, model, color, license plate #_____

Have you stayed in YWCA's shelter program before? ☐Y ☐ N When? _____

***(FOR STAFF ONLY:** If yes, does date or number # of stays require an Appeal? ☐Y ☐ N)*

HEAD OF HOUSEHOLD INFORMATION

Last Name:_____ M/I:___ First Name: _____ Cell Ph#:_____

Disabled? ☐Y ☐ N Type: _____ Social Security Number: ___ - __ -____ Date of Birth: _____ Age: _____

Gender: ☐ Male ☐ Female Veteran: ☐Y ☐N Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Citizenship: ☐U.S. Citizen ☐ Resident Alien ☐Immigrant ☐ Unknown

Last Grade Completed: _____ (*enter last grade completed or highest educational level*)

Has HOH signed release for data collection? ☐Y ☐N HOH Signed acknowledgement of Drug Testing Policy? ☐Y ☐N

Are you a sex offender? ☐Yes ☐No

Has HOH been arrested or served time in jail/prison? ☐Yes ☐No If yes, what was your crime? _____

Any Dietary Restrictions? ☐Y ☐N Explain: _____

SPOUSE/ SIGNIFICANT OTHER INFORMATION:

Last Name:_____ M/I:___ First Name: _____ Cell Ph#:_____

Disabled? ☐Y ☐ N Type: _____ **Social Security Number: ___ - __ -____ Date of Birth: _____ Age: _____**

Gender: ☐ Male ☐ Female **Veteran:** ☐Y ☐N **Race:** ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Citizenship: ☐U.S. Citizen ☐ Resident Alien ☐Immigrant ☐ Unknown

Last Grade Completed: _____ (*enter last grade completed or highest educational level*)

Has SO signed release for data collection? ☐Y ☐N SO Signed acknowledgement of Drug Testing Policy? ☐Y ☐N

Are you a sex offender? ☐Yes ☐No

Has SO been arrested or served time in jail/prison? ☐Yes ☐No If yes, what was your crime? _____

Any Dietary Restrictions? ☐Y ☐N Explain: _____

EMERGENCY CONTACT INFORMATION: (Please provide TWO ***local contacts*** if possible)

1) Name: _____ Relationship: _____ Day Ph: _____ Cell Ph: _____

2) Name: _____ Relationship: _____ Day Ph: _____ Cell Ph: _____

MEDICAL INFORMATION:

Tuberculosis Assessment

Has any member of your family exhibited any of the following conditions?

- Lost a lot of weight without trying? ☐Y ☐N If yes, who: _____
- Sweat a lot or have chills during sleep? ☐Y ☐N If yes, who: _____
- Coughing throughout the day for more than 3 weeks? ☐Y ☐N If yes, who:_____
- Coughing up blood? ☐Y ☐N If yes, who: _____

Physical Health History

Physician's name: _____ Date of last visit: _____
Primary hospital: _____ Medical insurance: _____

					Name	Name	Name
Allergies							
None	☐	☐	☐	☐	☐	☐	☐
Food	☐	☐	☐	☐	☐	☐	☐
Drug	☐	☐	☐	☐	☐	☐	☐
Insect	☐	☐	☐	☐	☐	☐	☐
Other							
Medical Conditions							
None	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐
Heart condition	☐	☐	☐	☐	☐	☐	☐
Sickle Cell	☐	☐	☐	☐	☐	☐	☐
AIDS/HIV	☐	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐	☐
Other							

Pregnancy

Is anyone in your family pregnant? ☐Y ☐N If yes, who: _____
Is she receiving prenatal care? ☐Y ☐N If yes, who: _____
Would you like information or a referral for pre-natal care? ☐Y ☐N If yes, who: _____

Mental Health History

Has anyone in your family ever received counseling? ☐Y ☐N If yes, who: _____
Diagnosis: _____
Worker: _____ Agency: _____ Phone: _____

Is anyone taking any medications for mental health reasons? ☐Y ☐N
If yes What Medications: _____

 HOH Initials: _____

Has anyone in your family expressed suicidal/homicidal or violent thoughts? ☐Y ☐N
If Yes, Explain: _____

Drug and Alcohol Use
When was the last time you or anyone in your family used alcohol or illegal drugs? _____
What substances did you or your family member use? _____
Have you or your family member ever been in treatment for substance abuse? _____
Are you currently interested in treatment for you or your family member? _____

CHILD WELFARE AGENCY INVOLVEMENT:

Have you ever been involved with a Children's Services agency in this or any other county/state? ☐Y ☐N
If yes, who was involved, when was case opened, and what were the circumstances?_____
_____

Has this issue been resolved? ☐Y ☐N If yes Explain: _____
Worker: _____ Phone: _____

What issue/circumstance brought you to the YWCA Family Center?

HOH Initials: _____

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CHILDREN'S INFORMATION: (*list family members under 18 living with HOH only*)

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐Y ☐ N

Disabled? ☐Y ☐ N Type: _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender:** ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: ____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐Y ☐ N

Disabled? ☐Y ☐ N Type: _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender**: ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐Y ☐ N

Disabled? ☐Y ☐ N Type: _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender:** ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐Y ☐ N

Disabled? ☐Y ☐ N Type: _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender**: ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

HOH Initials: _____

CHILDREN'S INFORMATION: (*list family members under 18 living with HOH only*)

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐**Y** ☐ **N**

Disabled? ☐**Y** ☐ **N Type:** _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender**: ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐**Y** ☐ **N**

Disabled? ☐**Y** ☐ **N Type:** _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender**: ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐**Y** ☐ **N**

Disabled? ☐**Y** ☐ **N Type:** _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender:** ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

Last Name: _____ **M/I**:____ **First Name**:_____
Residing in Family Center? ☐**Y** ☐ **N**

Disabled? ☐**Y** ☐ **N Type:** _____ **Social Security Number:** _____ - ____ -_____

Date of Birth: _____ Age: _____ **Gender**: ☐ Male ☐ Female
Race: ☐Black ☐ White ☐ Native American ☐ Asian ☐ Hispanic

Relationship to HOH:_____ School/Daycare Attending: _____ Grade: _____
Free/Reduced Breakfast? ☐Y☐N Lunch? ☐Y☐N Any dietary Restrictions? ☐Y ☐N Explain: _____

HOUSING INFORMATION:

Most recent address:_____ **City**:_____ **State:**_____ **Zip Code**: _____

Was Lease in your name? ☐Y☐N If No, Date Last Lease Agreement in your Name:_____

Address: _____ City:_____ State:_____ Zip Code: _____

Location of most recent residence: (Check One)

☐Columbus ☐Franklin County (but not Columbus) ☐Other Ohio County ☐Out of State

☐Unknown ☐If immigrant, country of origin: _____

Type of previous housing: (Check Box)

☐Own Home ☐Rent ☐Living with Family ☐Living with Friends

☐Emergency Shelter ☐Car/Streets ☐Substandard Housing ☐Nursing Home

☐Hospital ☐Psychiatric Facility ☐Treatment Center ☐Jail/Prison

☐Transitional Housing ☐Domestic Violence Shelter

Factors contributing to current housing crisis (Check one reason per column):

FACTORS	PRIMARY REASON	SECONDARY REASON
a. Loss of income/inadequate income	☐	☐
b. Poor money management/financial	☐	☐
c. Physical health problems	☐	☐
d. Family relationship problems	☐	☐
e. Drinking/drugs	☐	☐
f. Substandard housing/bad environment	☐	☐
g. Mental health problems	☐	☐
h. Arrested/went to jail	☐	☐
i. Fleeing abuse	☐	☐
j. Relocated to find work/decided to move here	☐	☐
k. No secondary reason for crisis	☐	☐

EMPLOYMENT INFORMATION: (*please list for all employed family members*):

PERSON EMPLOYED	PLACE OF EMPLOYMENT	# HRS WEEK	SCHEDULE	HOURLY WAGE	MONTHLY INCOME	PAY DATE
_____	_____	____	_____	$_____	$_____	_____
_____	_____	_____	_____	$_____	$_____	_____
_____	_____	_____	_____	$_____	$_____	_____
_____	_____	_____	_____	$_____	$_____	_____

 HOH Initials: _____

INCOME INFORMATION (*please list amounts for all family members*):

Person receiving	Alimony	Child Support	Retire-ment	SOC. SEC	SSDI	SSI	TANF	VA	Unemp
____	$____	$____	$____	$____	$____	$____	$____	$____	$____
____	$____	$____	$____	$____	$____	$____	$____	$____	$____
____	$____	$____	$____	$____	$____	$____	$____	$____	$____
____	$____	$____	$____	$____	$____	$____	$____	$____	$____
____	$____	$____	$____	$____	$____	$____	$____	$____	$____
TOTALS	**$____**	**$____**	**$____**	**$____**	**$____**	**$____**	**$____**	**$____**	**$____**

Total family income: (*not including food stamps*): $____** (Monthly Food Stamps **$____)

ADC/TANF/OWF/ODJFS INFORMATION:

Has HOH been enrolled in ADC/TANF/OWF any time since 1/1/97? ☐Y ☐N If Yes, How many times? ____

Has HOH been sanctioned by ADC/TANF/OWF any time since 1/1/97? ☐Y ☐N If Yes, How many times? ____

If Yes, Why were you sanctioned? ____ Is HOH Currently sanctioned? ☐Y ☐N If Yes, what county? ____

Has SO been enrolled in ADC/TANF/OWF any time since 1/1/97? ☐Y ☐N If Yes, How many times? ____

Has SO been sanctioned by ADC/TANF/OWF any time since 1/1/97? ☐Y ☐N If Yes, How many times? ____

If Yes, Why were you sanctioned? ____ Is SO Currently sanctioned? ☐Y ☐N If Yes, what county? ____

Who is your ODJFS Case Worker? ____ Ph #: ____ Case number: ____

Please check if HOH has applied for (or currently receiving):
☐Section 8 ☐Low income housing ☐Private Landlord Housing ☐PRC ☐Title XX

Does Application Include SO? ☐Y ☐N

Do you have any outstanding balances owed to any of the above? ☐Y ☐N If Yes, How much do you owe $ ____

SIGNATURES: (***FOR STAFF ONLY**: Before Printing, confirm that all information is complete and correct. After printing have HOH Initial each page and sign where indicated)*

X _____ **Date:** _____
Head of Household

X _____ **Date:** _____
Spouse / Significant Other

 HOH Initials: _____

_____

Family Center Staff Signature **Date**

---------- For Supervisor/Director Review----------

Supervisors review _____Date _____

Comments:

HOH Initials: _____

Release of Information by Franklin County Department of Job & Family Services to the YWCA Family Center

Head of Household Name: _____Social Security Number: _____ - ___ -_____

Spouse /Significant Other Name: _____ Social Security Number: _____ - ___ -_____

In accordance with Federal Regulations 42 CFR, Part 2, I hereby authorize the Franklin County Department of Jobs and Family Services to review information regarding any open cases or potential cases for me and my dependent children with the YWCA Family Center, 900 Harvey Court, Columbus, Ohio 43215, (614) 253-3910, for the purpose of determining appropriate next step housing for setting goal plans.

I release these organizations and their staff members from any legal liability that may arise from the release of information requested. I understand that the agency cannot release information obtained from other sources under this specific release. I understand that the individual or organization receiving information may not re-release it to any other individual or organization with my expressed permission. I understand this release will automatically expire 90 days after the below date.

X _____

HOH Signature Date

X _____

Spouse/SO Signature Date

X _____

Family Center Staff (Witness) Date

Print Witness Name: _____

ODOD TANF Eligibility Form Pg 1 of 2

HOH Initials: _____

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ODOD-TANF Eligibility Verification Form

1. Head of Household Name: _____

2. Head of Household(s) SSN: _____ - ___ -_____

3. Household is at or below 200% of poverty (80% AMI) ☒Yes ☐No

4. Household has received PRC assistance for the following expenses within the past 12 months:

Type	Date	Amount
☐ Rental Deposit	_____	$ ____
☐ Rental Assistance	____	$ _____
☐ Utility Assistance	____	$ _____
☐ Furniture	_____	$ ____
☐ Moving Assistance	_____	$ _____
☐ Appliances	_____	$ _____
☐ Other	_____	$ _____

5. Other Comments:

_____

6. Household currently receives the following benefits from FCDJFS:

☐ Ohio Works First
☐ Healthy Start
☐ WIC
☐ Public Child Care
☐ Head Start
☐ Food Stamps
☐ Medicaid
☐ Medicare
☐ Employment Assistance
☐ Other: _

7. If household is not receiving OWF, please describe if sanctioned, time-limited or other status: _____

_____

YWCA Advocate: _____ Date Given to FCDJFS: _____

----------For FCDJFS Use Only ----------

Verified By: _____ Date Returned to YWCA: _____

ODOD TANF Eligibility Form Pg 2 of 2

HOH Initials: _____

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FAMILY SYSTEM HOUSING SUMMARY / REFERRAL

(For Family Advocate only: Track #1 ☐ Track #2☐ Track #3☐)

HOH Name: _____

S O Name: _____

Gender	Adults (18+)	Children 5-17	Children 4 &under
Male	_____	_____	_____
Female	_____	_____	_____

1. Total Family Income $_____ Source(s) of Income: _____

2. Has HOH or SO been employed in the past (90)? Days ☐Y ☐N Is HOH or SO currently employed? ☐Y ☐N
If unemployed is there a reason why HOH or SO cannot work? ☐Y ☐N If YES, Why: _____

3. Does the family have a **Section 8** Certificate? ☐Y ☐N Does the family have any Housing Leads? ☐Y ☐N
Does family need assistance in securing housing? ☐Y ☐N

4. Exact number of evictions:_____ Any evictions within the past **90 days**? ☐Y ☐N
Any evictions from Low-Income Housing? ☐Y ☐N If Yes, where: _____

5. Does the family report high utility bills? ☐Y ☐N **Amounts:** Gas $_____Electric $_____

6. Check Number Documents Still Needed:
☐ TB Tests/results #: __ ☐Birth Certificate (s) #: __ ☐Social Security Cards(s) #: __
☐ Picture ID(s) #: __ ☐Police Reports #: __ ☐Verification of Income #: __

7. Is anyone in the family involved in mental health, chemical dependency or other counseling services? ☐Y ☐N
If Yes Explain (who, what services): _____ Is anyone in the household Pregnant? ☐Y ☐N

8. Is anyone in the family involved probation/parole or Children's Services? ☐Y ☐N
If Yes Explain (who, what services): _____

9. Does any family member have a criminal record? ☐Y ☐N Check **All that Apply:**
☐Theft ☐Arson ☐Drug Charges ☐Domestic Violence ☐Other Explain: _____

10. Has the family received any homeless or direct housing services in the past 12 months? ☐Y ☐N

11. Has the family used ALL 36 months of TANF/OWF? ☐Y ☐N If No How many months used? _____

12. Transportation Support Provided: ☐Gas Card ☐Bus Passes #:__ JOIN Referral Provided? ☐Y ☐N

FORWARED TO:
Family Advocate: _____ Appointment Date: _____ Time: _____
New Family Orientation Date: _____ Time: _____
Youth Services Orientation Date: _____ Time: _____

Housing Recommendation /Referral

☐Transitional Housing ☐Transition Funds Application ☐Direct Housing Program
☐Permanent Supportive ☐Tier II Emergency Shelter ☐Job2Housing

X_____ **Date:** _____
YWCA Staff

HOH Initials: _____

Job2Housing Self-Sufficiency Matrix

Matrix Summary
Intake Date _____/_____/_____
Staff Name: _____
Agency Name_____
Program Name: _____

Client Information
First Name_____ **MI**_____
Last Name _____ **Suffix**_____
Client ID (optional Agency ID) _____ **SS#** _____- _____- _____

Self-Sufficiency Matrix Instructions:
• Complete this form for all clients at: 1) entry, 2) at 6 months, 3) at 1 year post entry
• Select one and only one level in each of the 17 areas below by marking the box next to the appropriate level
• Level categories: 1 = In Crisis, 2 = Vulnerable, 3 = Safe, 4 = Building Capacity, 5 = Empowered

Assessment Type (Point in Time - select one): □ Entry □ 6 Month □ 1 Year

1. Income
□ 1. No Income
□ 2. Inadequate income and/or spontaneous or inappropriate spending
□ 3. Can meet basic needs with subsidy; appropriate spending
□ 4. Can meet basic needs and manage debt without assistance
□ 5. Income is sufficient, well managed; has discretionary income and is able to save

2. Employment
□ 1. No Job
□ 2. Temporary, part-time or seasonal; inadequate pay; no benefits
□ 3. Employed full-time; inadequate pay; few or no benefits
□ 4. Employed full-time with adequate pay and benefits
□ 5. Maintains permanent employment with adequate income and benefits

3. Shelter
□ 1. Homeless or threatened with eviction
□ 2. In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable
□ 3. In stable housing that is safe but only marginally adequate
□ 4. Household is safe, adequate, subsidized housing
□ 5. Household is safe, adequate, unsubsidized housing

4. Food
□ 1. No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost
□ 2. Household is on food stamps
□ 3. Can meet basic food needs but requires occasional assistance
□ 4. Can meet basic food needs without assistance
□ 5. Can choose to purchase any food household desires

5. Childcare
□ 0. N/A
□ 1. Needs childcare, but none is available/accessible and/or child is not eligible
□ 2. Childcare is unreliable or unaffordable; inadequate supervision is a problem for childcare that is available
□ 3. Affordable subsidized childcare is available but limited
□ 4. Reliable, affordable childcare is available; no need for subsidies
□ 5. Able to select quality childcare of choice

6. Children's Education
□ 0. N/A
□ 1. One or more eligible children not enrolled in school
□ 2. One or more eligible children enrolled in school but not attending classes
□ 3. Enrolled in school, but one or more children only occasionally attending classes
□ 4. Enrolled in school and attending classes most of the time
□ 5. All eligible children enrolled and attending on a regular basis

7. Adult Education
□ 1. Literacy problems and/or no high school diploma/GED are serious barriers to employment
□ 2. Enrolled in literacy and/or GED program and/or has sufficient command of English so language is not a barrier to employment
□ 3. Has high school diploma/GED
□ 4. Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able
to function effectively in society
□ 5. Has completed education/training needed to become employable. No literacy problems

8. Legal
□ 1. Current outstanding tickets or warrants
□ 2. Current charges/trial pending; noncompliance with probation/parole
□ 3. Fully compliant with probation/parole terms
□ 4. Has successfully completed probation/parole within past 12 months; no new charges filed
□ 5. No felony criminal history and/or no active criminal justice involvement in more than 12 months

9. Health Care
□ 1. No medical coverage with immediate need
□ 2. No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health
□ 3. Some members (Healthy Start, Health Families or children on State Children's Health Insurance Program)
□ 4. All members can get medical care when needed but may strain budget
□ 5. All members are covered by affordable, adequate health insurance

 HOH Initials: _____

10. Life Skills
□ 1. Unable to meet basic needs such as hygiene, food, activities of daily living
□ 2. Can meet a few but not all needs of daily living without assistance
□ 3. Can meet most but not all daily living needs without assistance
□ 4. Able to meet all basic needs of daily living without assistance
□ 5. Able to provide beyond basic needs of daily living for self and family

11. Mental Health
□ 1. Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems
□ 2. Recurrent mental health symptoms that may affect behavior but not a danger to self/others; persistent problems with functioning
due to mental health symptoms
□ 3. Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems
□ 4. Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning
□ 5. Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems/concerns

12. Substance Abuse
□ 1. Meets criteria for severe abuse; resulting problems so severe that institutional living or hospitalization may be necessary
□ 2. Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance
behaviors evident; use results in avoidance or neglect of essential life activities
□ 3. Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use
(such as disruptive behavior or housing problems); problems that have persisted for at least one month
□ 4. Client has used during last 6 months but no evidence of persistent or recurrent social, occupational, emotional, or physical
problems related to use; no evidence of recurrent dangerous use
□ 5. No drug use/alcohol abuse in last 6 months

13. Family Relations
□ 1. Lack of necessary support from family or friends; abuse (DV, child) is present or there is child neglect
□ 2. Family/friends may be supportive but lack ability or resources to help; family members do not relate well with one another;
potential for abuse or neglect
□ 3. Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to
communicate and support
□ 4. Strong support from family or friends; household members support each other's efforts
□ 5. Has healthy/expanding support network; household is stable and communication is consistently open

 HOH Initials: _____

14. Transportation/Mobility
□ 1. No access to transportation, public or private; may have car that is inoperable
□ 2. Transportation is available but unreliable, unpredictable, unaffordable; may have car but no insurance, license, etc.
□ 3. Transportation is available and reliable but limited and/or inconvenient; drivers are licensed and minimally insured
□ 4. Transportation is generally accessible to meet basic travel needs
□ 5. Transportation is readily available and affordable; car is adequately insured

15. Community Involvement
□ 1. No community involvement; in "survival" mode
□ 2. Socially isolated and/or no social skills and/or lacks motivation to become involved
□ 3. Lacks knowledge of ways to become involved
□ 4. Some community involvement (advisory group, support group) but has barriers such as transportation, childcare issues
□ 5. Actively involved in community

16. Safety
□ 1. Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement
□ 2. Safety is threatened/temporary protection is available; level of lethality is high
□ 3. Current level of safety is minimally adequate; ongoing safety planning is essential
□ 4. Environment is safe, yet future of such is uncertain; safety planning is important
□ 5. Environment is apparently safe and stable

17. Parenting Skills
□ 0. N/A
□ 1. There are safety concerns regarding parenting skills
□ 2. Parenting skills are minimal
□ 3. Parenting skills are apparent but not adequate
□ 4. Parenting skills are adequate
□ 5. Parenting skills are well developed

 HOH Initials: _____