I-CARE, Inc.
CSBG FAMILY ASSESSMENTS

CONFIDENTIALITY STATEMENT: Information shared with the case management staff will be kept strictly confidential unless its release is authorized in writing. These forms will be maintained in locked files.

Date Completed: _______________

Date(s) Revised: ________________

List the item numbers with changes

I. PERSONAL INFORMATION

1. Name of Head of Household ____

Birth Date ____________ Age ____ Sex ____ Race ___ Highest grade/education completed _____

Address __________________________________ City ______________________ Zip Code _________

Telephone Number(s) Home: ( ) ___________________ Work: ( ) __________________________

2. Child(ren) attending Head Start:

Name	Age	Sex	Date of Birth

3. Other children in home (under 18 years):

Name	Relationship to Head of Household	Age	Sex	Name of School	Current Grade

4. Other adults residing in the home (18 years and older):

Name	Relationship to Head of Household	Age	Sex	Highest Grade in School Completed

II. HEALTH (*Please describe any mental/physical and other health related conditions of members of their household. Write the* name of each person with such problems in the left column below. Then describe briefly the agency providing the services in the right-hand column.)

1. Does the individual/family have Medical or Dental Insurance, include Medicaid/Medicare? ☐ Yes ☐ No
   Type/Provider____

2. Describe any mental or physical handicaps:

Name	Handicapping Condition	Current Services/Agency
__________________	____________________________	____________________________
__________________	____________________________	____________________________
__________________	____________________________	____________________________

3. Describe any medical/dental/nutritional problems/concerns:

Name	Handicapping Condition	Current Services/Agency
__________________	____________________________	____________________________
__________________	____________________________	____________________________
__________________	____________________________	____________________________

III. INCOME

1. What is the family's gross income? (or income in last 90 days to 1 year) $______________ per year

Department of Health and Human Services Income Poverty Guideline will be used to ensure individual/family is eligible for CSBG services.
Documentation must be provided to verify income (pay stub, Unemployment Benefits, Department of Social Services, SSI, retirement, etc.)

Document Provided _______________________ Verified by _________________________________

IV. EDUCATION

1. Describe participation in adult education, vocational training programs, employment skills, and other specialized training of all adults in household.

Name of School	Training Experiences
_________________________________	____
_________________________________	____
_________________________________	____

2. Primary language spoken in the home:

____

V. EMPLOYMENT

1. Is the head of household employed? ____Yes ____No

   a. What type of work does the head of household do? ______________________________________

   b. What type of work would head of household like to do? ____________________________________

   c. Does the head of household need/want a job or if employed, a new job? ____Yes ____No

   d. Does the head of household need/want job training? ____Yes ____No

   e. What are problems preventing employment? ___Transportation __Child care __Health __Other

   Specify:____

2. a. Are other adults in the household employed? ____Yes ____No

   Who?____

   b. Do any unemployed adults need/want a job? ____Yes ____No

   Who?____

   c. Do any adults need/want job training? ____Yes ____No

   Who?____

VI. SOCIAL SERVICES

1. Has family received: (Check all boxes that apply for each service)

Services	Currently Receiving	Received in Past	Never Received
TANF Benefits	___	___	___
Emergency Food/Shelter	___	___	___
Employment and Training	___	___	___
Food Stamps	___	___	___
Head Start	___	___	___
Section 8 Housing – HUD	___	___	___
Medicaid/Medicare	___	___	___
Unemployment Compensation	___	___	___
Social Security/SSI Benefits	___	___	___
Nutrition/WIC Benefits	___	___	___
Other social services received	___	___	___

Specify:____

VII. FAMILY RESOURCES

1. Does family have a car? ___Yes ___No
   If no, what transportation is available to the family?____

2. Does family own or rent housing? ___Own ___Rent

   Does family have enough space? ___Yes ___No

   Does house/apartment need emergency repairs? ___Yes ___No

   Explain:____

   ____

3. What are the aspirations/goals of the family?

   ____

   ____

   ____

   ____

4. What are the strengths and resources of the family for achieving these aspirations?

   ____

   ____

   ____

   ____

Signatures:

___________________________________ ___________________________________
Family Member/Date Case Manager/Date

I-CARE, Inc.
CSBG Program Individual Inventory Sheet

Personal Skills Inventory	
Describe what you have been doing the past 6 months.	
Were you recently laid off?	
Have you ever been fired from a job?	
How many days did you miss on your last job? Example: 0-5, 6-10, or more than 11	
How often were you late for work?	
Can you work any shift? Or, what shift do you prefer?	
Are you available for Weekend shifts?	
Do you have transportation?	
How far are you willing to travel?	
Do you have physical limitations?	
Do you have problems following instructions?	
Do you have problems accepting guidance/criticism?	
Do you have computer/technology skills?	
Additional Comments	

Participant/Client Signature: ________________________________ Date: _____________________

Case Manager Signature: ___________________________________ Date:______________________

I-CARE, Inc.
CSBG Program Individual Inventory Sheet

Vocational Skills Inventory	
Do you have any degrees or certificates that can assist in gaining employment?	
Are you interested in receiving Occupational/Trade Training? If yes, what is your interest?	
What skills/experience do you have to assist with gaining employment?	
What jobs or skills are you interested in?	
Do you know the education/skills/qualifications needed to apply for jobs of interest?	
Are you familiar with computers? If yes, please describe experience or programs?	
Do you have a Career Readiness Certificate?	
Have received Soft Skills Training?	
Additional Comments	

Participant/Client Signature: ___________________________________ Date: ____________________

Case Manager Signature: _____________________________________ Date: ____________________

I-CARE, Inc.
CSBG Program

Goals Sheet

What is a goal?

____
____
____

Do you have any goals? ☐ Yes ☐ No

What are your short-term goals?

____
____
____

What are your long-term goals?

____
____
____

Where do you see yourself in 1 month?

____
____
____

Where do you see yourself in 6 months?

____
____
____

Where do you see yourself in 1 year?

Participant/Client Signature: ______________________________ Date: __________________

Case Manager Signature: ________________________________ Date: __________________