

KENTUCKY WORKS 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, please explain: _____

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

What kind of work 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, in order 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

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 on? _____ When? _____

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)

Did 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.?***