### Assessment Tool / Initial Home Visit

### Date Time Client Name

### Address

### *Program, may provide referrals and resources to stabilize the family, advocate for services to meet the family’s needs, provide financial assistance as determined by need, perform home visits (announced and unannounced), and/or provide information helpful towards achieving the family’s goals.*

## IDENTIFY ANY CRISIS THAT MAY EXIST

# Are you having any problems related to the following: None

Education  Family Separation  Incarceration  Budgeting  Employment

Mental Health Issues  Transportation  Housing  Family Conflict

Cultural/Loss of Identity  Juvenile/Behavioral Issues  Medical or Health Conditions

Substance Abuse  Financial Problems  Domestic Violence

Other

**Are you having residential problems related to the following:**  None

Plumbing  Plumbing Fixture Leaks  Drafts/Inadequate Insulation

Electrical Problems (lights flickering, frequent tripped breakers, outlet shorts, etc.)

Other

**Do you feel you need services in the following:**  None

Referrals for Counseling

Continuing Education  Parenting Classes  Stress Management  Anger Management

Drug/Alcohol Rehab  Domestic Violence Classes  Employment Assistance

Mental Health Treatment (Current Diagnosis)

Other

**What do you consider your family’s strength?**

Family Support  Culture/Traditions  Religion/Faith  Independence  Motivation/Drive

Education/Knowledge  Steady Employment (except during summer)  Ability to Accept Challenges

Other

**What do you consider your family’s weakness?**

Lack of Family Support  Lack of Culture/Tradition  Lack of Religion/Faith

Dependent on Family/Tribal Programs  Lack of Motivation/Drive/Self Esteem

Lack of Education/Knowledge  Unsteady Employment  Organization/Life Skills

Insufficient Income  Other

# Reason for Family Services Involvement:

**Conditions That Need To Be Corrected:**

1

2

3

4

**Service Plan Participants:**

|  |  |  |
| --- | --- | --- |
| **Name** | **DOB** | **Tribe** |
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