

HOPE CASE MANAGEMENT-PSYCHOSOCIAL ASSESSMENT

CLIENT INFORMATION:

Date: _____

Name: _____ Aliases: _____

SSN# _____ DOB ____/____/____ Age ____ Male Female

Birthplace _____ Caucasian Asian/Pacific Islander African American

Native American-Tribe: _____ Other/Specify: _____

Raised by: Intact family Mother only Father only Grandparents Other _____

Number of Siblings: _____ Mother's Name _____ Father's Name _____

Name @ Birth: _____

HOPE REFERRAL:

Referred by _____ on _____

Agency/phone # _____

One year disability statement provided? Yes No Other: _____

SOCIAL SECURITY/SSI:

Pending SSI/SSD? Date of application _____ Any previous SSI/SSD applications? Yes No

Date/location/outcome _____

Presently terminated/suspended from SSI/SSD? yes no

Where/why? _____

HOUSING/ADDRESS LOCATIONS FOR PAST 3 YRS:

Address: _____ City/State _____ Zip _____ Phone _____

Mailing Address: _____ City/State _____ Zip _____ Phone _____

Homeless Shelter Lives alone Roommate Lives with family Friends Group Home

Other _____ Length of Residency in Clark County _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Street _____ City _____ State ____ From: _____ to _____

Living situation for last 3 years:

HH Member: _____ Relationship _____ SSN _____ DOB _____ Age _____

HH Member: _____ Relationship _____ SSN _____ DOB _____ Age _____

HH Member: _____ Relationship _____ SSN _____ DOB _____ Age _____

HH Member: _____ Relationship _____ SSN _____ DOB _____ Age _____

Emergency Contact: _____

MARITAL STATUS:

Single Married Divorced Separated Widowed Significant other _____

1. Spouse _____ M/date _____ Status _____ yr _____ Children _____

2. Spouse _____ M/date _____ Status _____ yr _____ Children _____

3. Spouse _____ M/date _____ Status _____ yr _____ Children _____

MEDICAL HISTORY:

Diagnosis: _____

Doctor's Name/phone number _____

Permanently Disabled? Yes No. Statement provided? Yes No Pending _____

Date/type of disability: _____

Surgery(s) _____

Medications: _____

Medical Provider/records:

Hospitalizations: _____

MEDICAL COVERAGE:

CCSS/MAS/RX MAS Guarantee

Medicare A - Eff Date _____ Medicare B - Eff Date _____

MAABD Pending Date _____ MAABD - # _____ QMB SLMB

Private Health Insurance: name/phone number/policy number _____

Other _____

MENTAL HEALTH HISTORY:

Diagnosis: _____

Psychiatrist's Name/phone number: _____

Permanently Disabled? Yes No Statement Provided? Yes No Pending _____

Hospitalizations: _____

Medications: _____

Mental Health Providers/Records: _____

ALIEN STATUS:

Legal Permanent Resident A# _____ Entry Date _____ Expiration Date: _____

Work Authorization A# _____ Entry Date _____ Expiration Date: _____

Naturalized Citizen Date _____ Port of Entry _____

Undocumented/Illegal Sponsor(s) _____

Branch: _____ Dates of Service _____ / _____ Discharge Type _____

Served in combat?: Yes No If National Guard, ever activated? Yes No Registered with VA?: Yes No

If active military before 1968, eligible to receive benefits from a military or federal civilian agency? Yes No

EDUCATION:

Yes No-Can read? Yes No-Can write? Highest Grade Completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16+

HS Diploma GED Vocational Training Special Education College Degree _____

If special education, name of school/address: _____

TRANSPORTATION:

Self/Own Car Paratransit CAT Bus Family Friends Taxi CCSS SNAMHS

Has Bus Pass Received from: _____ Other: _____ None

EMPLOYMENT:

Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

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Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

Employer: _____ Job Title: _____ Pay rate: _____ Dates: _____ to _____

Ever Terminated? Yes No Date of last Termination: _____ Reason: _____

Unemployment Benefits: Yes No Date Applied: _____ Denied: Yes No Date: _____

Client/Spouse ever work for the Railroad, Federal Government or earned social security credits under another Country's social security system? Yes No

Date last worked: _____ Reason for not working: _____

VOCATIONAL REHABILITATION:

Date Attended: _____ to _____ Counselor's Name: _____ Phone: _____

Program Type: _____ Outcome: _____

FINANCIAL:

Alimony	\$ _____	Private Disability	\$ _____	Trust Income	\$ _____
Child Support	\$ _____	Retirement	\$ _____	UIB/Unemployment	\$ _____
CCSS/DAS	\$ _____	SSA	\$ _____	VA Pension	\$ _____
Energy Assist.	\$ _____	SSI	\$ _____	Workers Comp	\$ _____
Food Stamps	\$ _____	SSD	\$ _____	Widows/Survivors	\$ _____
Job/Wages	\$ _____	TANF/Foster Care	\$ _____		
Other income	\$ _____	_____			
Pension	\$ _____	_____			

ASSETS:

Checking - Bank Name: _____ Account: _____

Savings - Bank Name: _____ Account: _____

Trust Fund - Institution: _____ Account # _____

Land/Property - Location _____ Livestock _____

Stocks/Bonds \$ _____ CD \$ _____ 401K \$ _____ IRA \$ _____ Other \$ _____

Vehicle Year _____ Make/Model _____ License # _____ Value \$ _____ Payment \$ _____

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DEBTS:

Alimony or Child Support \$ _____

Rent \$ _____ Landlord's Name _____ Phone _____

Mortgage \$ _____ Mortgage Company _____ Acct # _____

Utilities \$ _____ (Power/Gas/Water) \$ _____

Health Insurance \$ _____ Company Name _____ phone _____

Life Insurance \$ _____ Company Name _____ Policy # _____

Term Life - Face Value \$ _____ Beneficiary _____

Whole Life - Cash Value \$ _____ Beneficiary _____

Burial Policy - Face Value \$ _____ Beneficiary _____

LUMP SUMS:

\$ _____ SSI Retro benefits - Date received _____

\$ _____ SSD Retro benefits - Date received _____

\$ _____ CD / IRA / 401K - Date Received _____

\$ _____ Lawsuits - Date Rec'd _____ Source _____ Atty's _____

\$ _____ Car Accidents - Date Rec'd _____ Insurance Company _____

\$ _____ Insurance Settlement - Date Rec'd _____ Insurance Company _____

LEGAL ISSUES:

Incarcerations: Yes No How Many? _____ Charges: _____

P/P Officer's Name _____ Phone _____ Outstanding Warrants: Yes No

Legal Guardian or Rep Payee? Name/address/phone _____

Other: _____

SUBSTANCE ABUSE/CHEMICAL DEPENDENCY:

Alcohol Cocaine Crack Crank MJ IVDU Inhalants Methadone Pain Meds

Other Prescription Meds _____ Other _____

Rehab/Treatment programs attended/attempted:

Client has signed the back release page of this assessment?

Wrkr Name: _____ Date _____ Pin #: _____ CCSS _____

Comments:
