

FAMILY SELF-SUFFICIENCY PROGRAM

PRE-ENROLLMENT FORM

Date \_\_\_\_\_

1. Please list all family members who live in your housing unit, including the head of household.  
Give the relationship of each family member to the head of household.

Family Member	Name of Family Member	Relationship to Head of Household	Age	Sex	Ethnic*
Head of Household		Self			

**Ethnic groups include:** White, African American, Hispanic, and American Indian Alaskan Native and Asian/Pacific Islander

2. Are you (head of household) employed? Yes  No

If yes, list your job and rate of pay: \_\_\_\_\_

Job: \_\_\_\_\_

Rate of pay: \$ \_\_\_\_\_ per  HR  Wk

If unemployed, what type of income do you receive? \_\_\_\_\_

\_\_\_\_\_

3. Are any other family members employed? Yes  No

If yes, please fill out the following information:

Family Member	Job	Rate of Pay (Indicate per hour/week)	
		\$	Per
		\$	Per
		\$	Per
		\$	Per
		\$	Per

4. Please check any items below that you consider a current need. *(Please check all that apply)*

Need a better job

Need better transportation

Need someone to take care of children problems

Need to see a doctor for health

Need more money to pay bills each month

Need help being a better parent

Want to finish school

Need Counseling

Need food assistance

Need help managing money

Job training

Please list other needs for services or goals you or your family have:

---



---



---



---

5. Please check the different agencies you have visited or received services from in the last six months.

- |  |   |
|--|---|
| <input type="checkbox"/> Health Department, doctor or clinic | <input type="checkbox"/> Community action Agency or<br>Community Services |
| <input type="checkbox"/> Job training program                | <input type="checkbox"/> Welfare Department                               |
| <input type="checkbox"/> Mental health center                | <input type="checkbox"/> Alcohol or drug program                          |
| <input type="checkbox"/> Food pantry                         | <input type="checkbox"/> Free meals program                               |
| <input type="checkbox"/> Head Start for child(ren)           | <input type="checkbox"/> Children's services program                      |
| <input type="checkbox"/> Community College                   | <input type="checkbox"/> None of the above                                |
| <input type="checkbox"/> Shelters                            |   |
| <input type="checkbox"/> Other (please list below)           |   |

---

---

6. Do you speak English? Yes  No

If no, what language (s) do you speak? \_\_\_\_\_

7. Do other family members speak English? Yes  No

If no, what language(s) do they Speak? \_\_\_\_\_

8. Do you have a high school diploma or GED? \_\_\_\_\_

9. If you were to get a job or change your job, would you need help finding someone to watch your children (Child care)? Yes  No

10. Do you now work with one person or a case manager who helps you and your family find the services you need? Yes  No

If yes, please list the person's name: \_\_\_\_\_

What agency does she/he work for? \_\_\_\_\_

11. Are you currently receiving Case Management Services from any agency?

Yes       No

If yes, what agency? \_\_\_\_\_

12. What are the two or three biggest problems that YOU are facing now?

---

---

---

---

---

---

---

---

13. What are the two or three biggest problems currently face by YOUR FAMILY?

---

---

---

---

---

---

---

---

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_