

Coordinated Services Team Initiative

Summary of Strengths & Needs – Adult Participant

All information gathered is confidential.

Name: _____ **Date of Birth:** _____
Address: _____ **Social Security #:** _____
 _____ **Phone:** _____

Family Members

Relationship	Name	Race*	Date of Birth	Gender	Marital Status*	Education Level*	Mailing Address (If different from above information)

***List of Codes:**

Race: **AI** = American Indian, **A/P** = Asian/Pacific Islander, **B** = Black or African American, **H** = Hispanic, **W** = White, **M** = Mixed Race/Ethnicity
Marital Status: **Sg** = Single, **M** = Married, **Sp** = Separated, **D** = Divorced, **W** = Widowed, **LT** = Living Together
Educational Level: **01** = Elementary, **02** = Junior High, **03** = Some High School, **04** = High School Diploma/GED, **05** = Some College, **06** = College Degree
07 = Some Graduate School, **08** = Masters, **09** = Ph.D., **10** = Business/Trade School

Service Coordinator: _____ **Dates Updated:** _____
Start Date of Initial Assessment: _____
Date Assessment Completed: _____

Medical Insurance & Income Sources:

= MA = SSI = Private Insurance = Employment
 = Parents = Other: _____

CRISIS/SAFETY

“A crisis occurs when adults don’t know what to do.” - Carl Shick

Is This an Area of Strength?

Level of Need
(1=No need, 5=Great need)

Have there been any crisis situations at home or in the community?

Strength

Safety Plan for Home
 1 2 3 4 5
Person(s) in Need:

What was done in response to the situation(s)?

Strength

Safety Plan for Community
 1 2 3 4 5
Person(s) in Need:

Have there been any crisis situations at work?

Strength

Safety Plan for School
 1 2 3 4 5
Person(s) in Need:

What was done in response to the situation(s)?

Strength

Other Strengths:

Other Needs:

LIVING SITUATION

	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
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1. Describe your current living situation. Do any family members live at home? <i>Describe:</i>	<input type="checkbox"/> Strength	Living Arrangement <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
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2. Does your home provide enough space, privacy and comfort? <i>Describe:</i>	<input type="checkbox"/> Strength	Space, Privacy & Comfort <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
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3. Are there barriers to living in your current home long-term? <i>Describe:</i>	<input type="checkbox"/> Strength	Stability of Living Arrangement <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
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4. Are there any safety concerns? <i>Describe:</i>	<input type="checkbox"/> Strength	Safety of Physical Environment <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
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5. Group, Adult Family Home, Institutional Placement History		
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Other Strengths:	Other Needs:
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FAMILY		
	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
1. Describe relationships among family members:	<input type="checkbox"/> Strength	Family Relationships <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
2. Describe relationships with your extended family – are they a resource to your family?	<input type="checkbox"/> Strength	Extended Family Resource <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
3. Who (other than family members) offers support to you and your family?	<input type="checkbox"/> Strength	Social Support Network <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
Other Strengths:	Other Needs:	

BASIC NEEDS/FINANCIAL

Is This an Area of Strength?

Level of Need
(1=No need, 5=Great need)

1. Are your housing, food, and clothing needs met?

Strength

Basic Needs
 1 2 3 4 5
Person(s) in Need:

2. Are your transportation needs met?

Strength

Transportation
 1 2 3 4 5
Person(s) in Need:

3. Please indicate your gross yearly income: _____ . What are your sources of income? Is there enough income to meet your needs?

Strength

Financial Resources
 1 2 3 4 5
Person(s) in Need:

4. Please describe your money management skills:

Strength

Social Support Network
 1 2 3 4 5
Person(s) in Need:

5. Do family members have access to child care when needed – while adults are at work and when family members “just need a break”?

Strength

Child Care &/or Respite
 1 2 3 4 5
Person(s) in Need:

Other Strengths:

Other Needs:

MENTAL HEALTH

1. Describe any significant psychological/psychiatric individual family history:

Is This an Area of Strength?

Level of Need
(1=No need, 5=Great need)

2. Describe cognitive strengths and needs (learning ability, problem solving & thinking skills) of yourself and family members:

Strength

Cognitive Functioning
 1 2 3 4 5
Person(s) in Need:

3. Describe emotional strengths and needs (reaction to stress, stability of mood) of your self and family members:

Strength

Emotional Functioning
 1 2 3 4 5
Person(s) in Need:

4. Do you have access to the mental health service providers you and your family needs or wants?

Strength

Access to Mental Health Providers
 1 2 3 4 5
Person(s) in Need:

Other Strengths:

Other Needs:

AODA (Alcohol and Other Drug Abuse)

	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
<p>1. Describe any current AODA abuse or addiction concerns regarding you or other family members:</p>	<p><input type="checkbox"/> Strength</p>	<p>Current AODA abuse or addiction <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____</p>
<p>2. Describe past AODA abuse or abuse or addiction concerns regarding you or other family members:</p>	<p><input type="checkbox"/> Strength</p>	<p>Past AODA abuse or addiction <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____</p>
<p>3. Do you and family members have access to needed AODA treatment and support?</p>	<p><input type="checkbox"/> Strength</p>	<p>Access to AODA treatment & support <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need:: _____</p>
<p>4. Describe the impact AODA issues have had on yourself and family members, both currently and in the past (include impact on social/community and family relationships, as well as on financial, legal, and employment situations):</p>	<p><input type="checkbox"/> Strength</p>	<p>Impact of AODA issues <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____</p>
<p>Other Strengths:</p>	<p>Other Needs:</p>	

MENTAL HEALTH/AODA (Continued)

Please Complete the following Mental Health DSM IV Diagnosis information.

DSM IV DIAGNOSIS		
AXIS	NUMBER	NAME OF DIAGNOSIS
AXIS II		
AXIS III	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
AXIS IV Social Stressors (1 = mild / 6 = severe)	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6	
AXIS V GAF Score Use GAF from Intake		
Diagnosed by:		
Date of Diagnosis:		
On medication at start date of services?	<input type="checkbox"/> Yes or <input type="checkbox"/> No	
If yes, specify medication and daily dosage:		

Medication History:

Hospitalization History:

SOCIAL & RECREATIONAL

	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
<p>1. Social interactive skills: Do you have friends – why or why not? Do you get along well with others?</p>	<input type="checkbox"/> Strength	<p>Social Interactive Skills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Person(s) in Need: _____</p>
<p>2. Describe activities family members currently do together or would like to do together:</p>	<input type="checkbox"/> Strength	<p>Family Activities <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Person(s) in Need: _____</p>
<p>3. Describe activities you or family members are involved in, or would like to be involved in, as individuals:</p>	<input type="checkbox"/> Strength	<p>Individual Social & Recreational Activities <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Person(s) in Need: _____</p>
<p>4. Describe social relationships – do you and family members spend time with people outside your immediate family?</p>	<input type="checkbox"/> Strength	<p>Social Relationships <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5</p> <p>Person(s) in Need: _____</p>
<p>Other Strengths:</p>	<p>Other Needs:</p>	

CULTURAL**Is This an Area of Strength?****Level of Need**
(1=No need, 5=Great need)**1. Describe ethnic or national traditions/holidays your family observes:** Strength**Affiliation with Ethnic Group** 1 2 3 4 5**Person(s) in Need:**
_____**2. How do you and your family members participate in these traditions? Are there any barriers to participating in those traditions?** Strength**Access to Ethnic Traditions** 1 2 3 4 5**Person(s) in Need:**
_____**Other Strengths:****Other Needs:****SPIRITUAL****Is This an Area of Strength?****Level of Need**
(1=No need, 5=Great need)**1. Describe your religious or spiritual practices, values, and support network:** Strength**Affiliation with religious or spiritual group** 1 2 3 4 5**Person(s) in Need:**
_____**2 Do you have access to desired spiritual practices and support:** Strength**Access to desired practices and support** 1 2 3 4 5**Person(s) in Need:**
_____**Other Strengths:****Other Needs:**

EDUCATIONAL/VOCATIONAL		
	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
1. Describe your educational history:	<input type="checkbox"/> Strength	Education <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
2. Describe your employment history:	<input type="checkbox"/> Strength	Employment <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
3. Describe how your child is doing behaviorally in school:	<input type="checkbox"/> Strength	Behavior in School <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
4. Do family members have age-appropriate independent living skills?	<input type="checkbox"/> Strength	Independent Living Skills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
5. If applicable, describe your child's work experience, pre-employment skills and interests:	<input type="checkbox"/> Strength	Pre-employment Skills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
6. Describe any educational or vocational strengths and needs of adult family members:	<input type="checkbox"/> Strength	Parent Education or Vocational Skills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: _____
Other Strengths:	Other Needs:	

MEDICAL

Is This an Area of Strength?

Level of Need
(1=No need, 5=Great need)

1. Describe the physical health of yourself and family members:

Strength

Physical Health
 1 2 3 4 5
Person(s) in Need:

2. Describe the dental health of yourself and family members:

Strength

Dental Health
 1 2 3 4 5
Person(s) in Need:

3. Do you and your family members have access to needed health equipment or supplies?

Strength

Access to Special Equipment
 1 2 3 4 5
Person(s) in Need:

4. Do you and your family members have access to needed dental and health care providers?

Strength

Access to Dental & Health Care Providers
 1 2 3 4 5
Person(s) in Need:

Other Strengths:

Other Needs:

Independent Living Skills

	Is This an Area of Strength?	Level of Need (1=No need, 5=Great need)
1. Personal hygiene:	<input type="checkbox"/> Strength	Personal Hygiene <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: <hr style="width: 100%;"/>
2. Describe your housekeeping and laundry skills:	<input type="checkbox"/> Strength	Housekeeping <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: Mary <hr style="width: 100%;"/>
3. Describe your nutrition and food preparation skills:	<input type="checkbox"/> Strength	Nutrition <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: <hr style="width: 100%;"/>
4. Describe your parenting skills:	<input type="checkbox"/> Strength	Parenting Skills <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 Person(s) in Need: <hr style="width: 100%;"/>
Other Strengths:	Other Needs:	