

St. Vincent de Paul - Family Support Services - Client Assessment

We acknowledge that discussing personal matters can sometimes trigger difficult emotions or memories. Your comfort and well-being are our top priorities. Your responses will not influence the outcome of your request for assistance, and you have the choice to decline to answer any questions. Our aim in gathering this information is to continually enhance our program in a way that respects and supports the needs of individuals who seek our assistance.

Client Name: _____

Demographic Information:

- Race: ___ American Indian/Alaska Native
 ___ Asian American
 ___ Black/African American
 ___ Native Hawaiian/Other Pacific Islander
 ___ White
 ___ Other
 ___ Declined to Share
 ___ Multiracial
- Ethnicity: ___ Hispanic/Latino
 ___ Non-Hispanic Latino
 ___ Unknown
 ___ Declined to Share

1. What is the household's current sources of income?
 ___ No Income
 ___ Employment
 ___ Unemployment
 ___ SSI/SSDI
 ___ Pension
 ___ Friends/Relatives
 ___ Other - _____
 ___ Declined to answer
2. If you're employed, how long have you been with your current employer?
 ___ Newly hired, have not started yet
 ___ 1-3 months
 ___ 4-6 months
 ___ 7-12 months
 ___ More than 12 months
 ___ Declined to answer

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3. Are there any benefit programs that your household participates in to support its needs?
 - SNAP (food stamps)
 - Cash Assistance
 - Childcare Assistance
 - Section 8 Housing
 - Low Income Energy Program
 - Women/Infant Children (WIC)
 - Declined to answer
4. What type of health coverage does your household currently have in place?
 - None
 - Private Insurance
 - AHCCCS
 - Healthcare.gov -Obama Care
 - Other
 - Declined to Answer
5. Does anyone in your household experience health challenges or concerns?
 - Yes
 - No
 - Declined to answer
6. Do you live with a disability that impacts daily life?
 - Yes
 - No
 - Declined to answer
7. If answered yes, could you share more about it?
 - Alcohol Use Disorder
 - Drug Use Disorder
 - Chronic Health Condition
 - Developmental Disability
 - HIV/AIDS
 - Mental Health Disorder
 - Physical Disability
 - Declined to Answer
8. Does anyone in your household live with a disability or health condition that impacts daily life?
 - Yes
 - No
 - Declined to answer

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9. If there's a disability present, could you share more about it? (Please select all that apply)
- Alcohol Use Disorder
 - Drug Use Disorder
 - Chronic Health Condition
 - Developmental Disability
 - HIV/AIDS
 - Mental Health Disorder
 - Physical Disability
 - Declined to Answer
10. Over the past year, have you ever experienced hunger but couldn't afford to buy food?
- Yes
 - No
 - Declined to Answer
11. In the past year, have you ever needed medical care but couldn't access it due to financial constraints?
- Yes
 - No
 - Declined to Answer
12. Over the past year, have you ever struggled to make payments on bills due to financial limitations? (pick all that apply)
- Rent or Mortgage
 - Utilities
 - Credit cards
 - Car Payment
 - Insurance
 - Other - _____
 - Declined to answer