
## 2020 Needs Assessment Form

**Date**: _____

**Caller's Name:** _____

**Phone**: _____ **Email:** _____

**********

## Client Info:

**First**: _____**Last**: _____ **Age**: ____ **Race:** _____

**Address**: _____ **Apt/Ste**: _____

**City**: _____ **St**: _____ **Zip**: _____ **County**: _____

**Phone**: _____**Email:** _____

**Referred From**: _____

**Assistance Needed**:

_____

_____

_____

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**Are you employed? ____ Where? _____ Monthly Household income: $_____**

**Is there a specific way your family has been impacted by COVID19:**

_____

_____

_____

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**Would it help you to get extra food? _____**

**Do you have transportation? _____ self, _____family, _____ friend, _____ public transportation.**

**In no, can someone pick up food for you?_____**

**Assistance Received:**

_____

_____

_____

**Referred To**:

_____

_____

## ADDITIONAL INFORMATION NEEDED TO IDENTIFY AVAILABLE FREE SERVICES

**Circle: Single/Widow/Married/Divorced**

**Denomination or Home Church** _____

**Receiving (please circle the services that the client or a client's dependent is currently receiving):**

**SNAP** **Disability** **Social Security** **SSI** **VA Disability** **Medicare**

**Medicaid** **Unemployment** **Section 8**

**# of Household Members**: _____ **# of Dependents**: _____

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Name**: _____, **Age**: _____, **Disability**: Yes No, **Dependent**: Yes No

**Additional Notes:**

_____

_____

_____

_____

**Staff Initials:** _____