Maryland
Department of Human Services
ALLEGANY COUNTY
Department of Social Services

SHINE Program Intake Assessment

DATE: _____

DEMOGRAPHIC INFORMATION:

NAME: _____

BIRTH DATE: _____ CASE NUMBER: _____

ADDRESS: _____

_____

PHONE #: _____ CALL and/or TEXT: _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT NAME & NUMBER: _____

DOCUMENTATION & TRANSPORTATION:

DRIVER'S LICENSE: YES ☐ NO ☐ MARYLAND ID/OTHER PICTURE ID: YES ☐ NO ☐

TRANSPORTATION: YES ☐ NO ☐ LICENSE CURRENTLY SUSPENDED: YES ☐ NO ☐

IF SUSPENDED, FOR WHAT: _____

SOCIAL SECURITY CARD: YES ☐ NO ☐ BIRTH CERTIFICATE: YES ☐ NO ☐

SUBSTANCE ABUSE & LEGAL HISTORY:

LEGAL ISSUES/CRIMINAL RECORD: YES ☐ NO ☐ EXPUNGEMENT: YES ☐ NO ☐

IF YES, IN WHAT STATE/COUNTY: _____

FINANCIAL RESOURCES:

MONTHLY INCOME AND SOURCE OF INCOME: $ _____

_____

SNAP BENEFITS: YES ☐ NO ☐ AMOUNT OF BENEFIT: _____

CURRENT LIVING ARRANGEMENTS:

DO YOU HAVE A FIXED, REGULAR, AND ADEQUATE NIGHTTIME RESIDENCE: YES ☐ NO ☐

DO YOU CURRENTLY LIVE IN AN EMERGENCY OR TRANSITIONAL SHELTER: YES ☐ NO ☐

DO YOU RESIDE ON YOUR OWN: YES ☐ NO ☐ PAY YOUR OWN EXPENSES: YES ☐ NO ☐

DO YOU RESIDE WITH RELATIVE(S) OR FRIEND(S), WHO HELP PAY EXPENSES: YES ☐ NO ☐

NAME(S) OF RELATIVE(S) OR FRIEND(S) LIVING WHERE YOU RESIDE:

_____

DEPENDANTS:

CHILDREN YOU HAVE _____ # CHILDREN LIVING WITH YOU _____ NEED CHILD CARE: YES ☐ NO ☐

NAME & DOB OF CHILDREN LIVING WITH YOU:

_____

ADDITIONAL COMMENTS REGARDING CUSTODY/VISITATION:

_____

DOMESTIC VIOLENCE: ARE YOU IN A RELATIONSHIP WHERE YOU ARE YOU AFRAID SOMEONE MIGHT HURT YOU OR YOUR CHILDREN PHYSICALLY, MENTALLY OR SEXUALLY: YES ☐ NO ☐

DOMESTIC VIOLENCE SERVICE PROVIDER: YES ☐ NO ☐ WANT A REFERRAL: YES ☐ NO ☐

MEDICAL:

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR, PSYCHOLOGIST, OR THERAPIST FOR A MEDICAL CONDITION OR MENTAL HEALTH CONDITION: YES ☐ NO ☐

IF YES, PLEASE EXPLAIN YOUR MEDICAL CONDITION:

_____

SUBSTANCE ABUSE HISTORY: YES ☐ NO ☐ ARE YOU CURRENTLY IN TREATMENT: YES ☐ NO ☐IF

YES, WHERE: _____

MEDICAL INSURANCE: YES ☐ NO ☐ HAVE YOU APPLIED FOR DISABILTY: YES ☐ NO ☐

EDUCATION & EMPLOYMENT:

HIGHEST GRADE COMPLETED: _____ DIPLOMA/GED _____ DEGREE_____

CURRENT CERTIFICATIONS/LICENSES: _____

MILITARY/VETERAN: YES ☐ NO ☐ BRANCH: _____ FORM DD214: YES ☐ NO ☐

HONORABLE DISCHARGE: YES ☐ NO ☐ VA BENEFITS/SERVICES: YES ☐ NO ☐

DIFFICULTY READING OR UNDERSTANDING ENGLISH: YES ☐ NO ☐

ARE YOU CONFIDENT IN YOUR ABILITIES TO WRITE A RESUME AND/OR COMPLETE EMPLOYMENT APPLICATIONS: YES ☐ NO ☐ CAN YOU USE A COMPUTER: YES ☐ NO ☐ DO

YOU HAVE COMPUTER ACCESS: YES ☐ NO ☐

EXPLAIN ANY ADDITIONAL BARRIERS OR PERSONAL ISSUES YOU EXPERIENCE THAT MIGHT BE KEEPING YOU FROM GAINFUL EMPLOYMENT. _____

_____

SKILLS AND INTERESTS:

WHAT TYPE OF EMPLOYMENT ARE YOU MOST INTERESTED IN WORKING IN:

_____

WHAT TYPES OF TRAINING/EDUCATION PROGRAMS WOULD YOU BE INTERESTED IN COMPLETING:

_____

TELL US ABOUT YOUR JOB SKILLS:
(EXAMPLES- answering phones, customer service, construction, using tools, retail, forklift)

_____

TELL US ABOUT YOUR LAST JOB:

EMPLOYER'S NAME: _____

ADDRESS: _____

PAY RATE: _____ START & END DATE: _____ WHY DID YOU LEAVE THIS JOB?
_____ JOB DUTIES: _____

SHINE SERVICE PLAN

SETTING GOALS & OUTCOMES:

For Example: Get my driver's license, become a CNA, gain employment, etc.

GOAL#1:_____

STEPS TO TAKE TO ACCOMPLISH YOUR GOAL

1)_____

2)_____

3)_____

I'D LIKE TO ACCOMPLISH GOAL ONE BY: _____

GOAL#2: _____

STEPS TO TAKE TO ACCOMPLISH YOUR GOAL

1)_____

2)_____

3)_____

I'D LIKE TO ACCOMPLISH GOAL TWO BY: _____

GOAL#3: _____

STEPS TO TAKE TO ACCOMPLISH YOUR GOAL

1)_____

2)_____

3)_____

I'D LIKE TO ACCOMPLISH GOAL THREE BY: _____

CUSTOMER SIGNATURE: _____ DATE: _____

NPEP SPECIALIST SIGNATURE: _____ DATE: _____