Case No._____

CITY OF OLYMPIA MUNICIPAL COURT

NEEDS ASSESSMENT FORM

NAME (Last, First, MI): DOB: DATE:

CHARGE(S):

ARE YOU CURRENTLY TRESPASSED FROM ANYWHERE? ___ Yes ___ No WHEN TRESPASSED?_____
Comments:

Ethnicity/Race: Ethnic origin (please select one of the following): _____ Hispanic / Latino _____ White _____ Black / African American
_____ Native Hawaiian / Other Pacific Islander _____ American Indian / Alaska Native _____ Asian

Do you have a valid ID Card? _____Yes _____No Receiving any type of State Assistance? ____Yes ___No

Food Stamps _____ TANF _____ GAU /ABD _____ Medicaid _____ SSI/SSDI/DSHS _____ Other _____

DEPENDENCY: (Number of people you legally and financially support?) Children ___ Ages: ___ ___ ___ ___ ___

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Separated ___ In a relationship? ___YES ___NO

Are your children in foster care? Do you have family support? Who? What type?

ADDRESS/PHONE#/EMAIL:

Is this a permanent address? Y or N Transient? Y or N Homeless? Y or N How long? ___ Why homeless?

EDUCATION: (Please indicate your highest level of education)

MILITARY: Have you ever been in the military? Y or N Active Duty? Y or N Reserve/National Guard? Y or N

Branch of Service? _____Years? _____ PTSD? Y or N TBI? Y or N MST? Y or N Discharge Status_____

EMPLOYMENT:
Employed? ___ Unemployed? ___ How long? _____ Occupation? _____ Wage per hour? _____ Hrs. per wk. _____
Name and Location of Employer? _____ Unemployed reason _____
Job Skills/Comments: _____

ALCOHOL/DRUG/DV:
Current A/D of Choice? _____ How long? _____ Previous A/D Issues? _____
Clean/sober how long? _____ Currently/previously in TX, where/when?_____

Are you a victim of Domestic Violence or a violent crime? Y N Do you want services? Y N
PRESCRIPTION MEDS TAKEN/COMMENTS:

MENTAL HEALTH: Has anyone ever advised you to seek counseling or mental health services? Y or N
Have you ever sought help in a hospital setting for anxiety, sadness, depression, or psych issues? Y or N
Would talking with someone be helpful to you in working on some life issues or concerns? Y or N
COMMENTS:_____

PHYSICAL DISABILITIES: Do you have Health Insurance? Y or N _____
Name of Insurance Provider

Primary Care Doctor? Preference Health Care Facility?

ADDITIONAL NOTES:

Case No._____

CITY OF OLYMPIA MUNICIPAL COURT

NEEDS ASSESSMENT FORM

NAME (Last, First, MI): DOB: DATE:

CHARGE(S):

What needs do you have in order to not break the law? _____

SOCIAL SERVICE CONTACT REFERRALS (check all that apply):

- ❑ No Referral Recommended
- ❑ Drug/Alcohol Eval/TX Program
- ❑ Employment Services
- ❑ Education/Literacy
- ❑ Victim Counseling
- ❑ DSHS
- ❑ Medical Needs/Assessment
- ❑ Mental Health Services
- ❑ SeaMar
- ❑ Legal Assistance
- ❑ Affordable Care Act Rep
- ❑ Native Amer Services
- ❑ Veteran Services
- ❑ MRT program
- ❑ Department of Licensing
- ❑ Housing _____

❑ Other _____

ADDITIONAL NOTES: