

Attachment 1:

Defendant Screening Initiative Needs Screen Instrument Template

ANSWER Sheet

Arraignment Needs Screen With Early Referral

NYS DCJS, December 2016



**Division of Criminal
Justice Services**

CASE

Docket # _____ Arrest Date: _____ NYSID: _____

Screener Name: _____ Screen Date/Time: _____

Consent to Screening: Y N Participant Signature: _____

BACKGROUND

Name: _____ AKA/Preferred Name: _____ Age: _____

Gender: _____ Marital Status: _____ Govt ID? _____ Driver's License? _____ Contact Ph #: _____

What, if any, benefits/assistance do you currently receive? _____

Existing Service Relationship

Are you currently in any type of service or treatment program? (If yes, describe in notes box below.) _____

Veteran

Have you served in the Military? _____ Do you qualify for Veteran Benefits? _____

HOUSING

Do you have a stable place to live? _____ Describe, Who's place is it? _____

Need Identified

How many nights/week do you sleep there? _____ Is there anywhere else you stay? _____

Screener Referred

Do you have any children/dependents that live with you? _____

Court Referred

EDUCATION

What is the highest level of education you completed? _____ What year was that? _____

Need Identified

Are you currently enrolled in any school or training program? _____ Where? _____

Screener Referred

Do you have any problems speaking or understanding English? _____

Court Referred

Do you have difficulty: Reading _____ Writing _____ Adding/Subtracting _____ Concentrating _____

EMPLOYMENT

Are you currently working? _____ Where? _____

Need Identified

How many hours/week? _____ How much do you get paid? _____

Screener Referred

Do you have any other sources of income? (including unemployment)? _____

Court Referred

If not working, What keeps you from working? _____

SUBSTANCE ABUSE

Have you ever used drugs other than medicine prescribed to you by a doctor? _____

Need Identified

What types? _____ How much/how often? _____

Screener Referred

When was the last time you used? _____

Court Referred

Do you drink alcohol? _____ How often do you have 6 or more drinks in one day? _____

Would you say you have a problem with drugs or alcohol? _____

Immed Care Reqd

Have you ever been to drug or alcohol treatment? _____ When was the last time? _____

MENTAL HEALTH

Are you currently receiving mental health counseling? _____ Where? _____

Need Identified

Have you ever had a mental health evaluation? _____ When? _____

Screener Referred

Do you have a mental health diagnosis? _____ What is it? _____

Court Referred

Ever been hospitalized for mental health matters? If so, when was the last time? _____

Have you ever tried to harm yourself? _____ When was that? _____

Immed Care Reqd

Do you currently have any plans or thoughts of harming yourself or others? _____

Other Needs / Notes: _____