LEARNING NEEDS SCREENING TOOL DIRECTIONS

1. Ask the client each question in each section (A, B, C, D) and question #14.

2. Record the client’s responses, checking “Yes” or “No.”

3. Count the number of “Yes” answers in each section.

4. Multiply the number of “Yes” responses in each section by the number shown in the section subtotal. For example, multiply the number of “Yes’s” obtained in Section C by 3.

5. Record the number obtained for each section after the “=” sign in the section subtotal.

6. To obtain a Total, add the subtotals from Sections A, B, C, and D.

If the Total from Sections A, B, C, and D is 12 or more, refer for further assessment.

Interviewers must ask the additional set of medical/health-based questions to gather more complete background information.

Refer to the Learning Needs Screening Tool Question and Descriptions and Follow-up Explanations to clarify terms and meanings to obtain an accurate response from the participant.

BEFORE PROCEEDING TO THE QUESTIONS, READ THIS STATEMENT ALOUD TO THE CLIENT:

The following questions are about your school and life experiences. We’re trying to find out how it was for you (or your family members) when you were in school or how some of these issues might affect your life now. Your responses to these questions will help identify resources and services you might need to be successful securing employment.
**LEARNING NEEDS SCREENING**

<table>
<thead>
<tr>
<th>Interviewer Name: __________________________</th>
<th>Interview Date: __________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Name: ______________________________</td>
<td>Date of Birth: ____________________________</td>
</tr>
<tr>
<td>Case ID #: ________________________________</td>
<td>Gender: __ Male __ Female</td>
</tr>
</tbody>
</table>

How many years of schooling have you had?

Check ALL earned: __ High School Diploma __ GED __ Technical/Vocational Certificate __ AA Degree __

Other (specify): ____________________________

What kind of job would you like to get?

Do you have experience in this area? __ Yes __ No

What makes it hard for you to get or keep this kind of job?

What would help?

<table>
<thead>
<tr>
<th>Section A</th>
<th>1. Did you have any problems learning in middle school or junior high school?</th>
<th>__ Yes __ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Do any family members have learning problems?</td>
<td>__ Yes __ No</td>
</tr>
<tr>
<td></td>
<td>3. Do you have difficulty working with numbers in columns?</td>
<td>__ Yes __ No</td>
</tr>
<tr>
<td></td>
<td>4. Do you have trouble judging distances?</td>
<td>__ Yes __ No</td>
</tr>
<tr>
<td></td>
<td>5. Do you have problems working from a test booklet to an answer sheet?</td>
<td>__ Yes __ No</td>
</tr>
</tbody>
</table>

**Count the number of “Yeses” for Section A X 1 =**

<table>
<thead>
<tr>
<th>Section B</th>
<th>6. Do you have difficulty or experience problems mixing arithmetic signs (+/x)?</th>
<th>__ Yes __ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7. Did you have any problems learning in elementary school?</td>
<td>__ Yes __ No</td>
</tr>
</tbody>
</table>

**Count the number of “Yeses” for Section B X 2 =**

<table>
<thead>
<tr>
<th>Section C</th>
<th>8. Do you have difficulty remembering how to spell simple words you know?</th>
<th>__ Yes __ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>9. Do you have difficulty filling out forms?</td>
<td>__ Yes __ No</td>
</tr>
<tr>
<td></td>
<td>10. Did you (or do you) experience difficulty memorizing numbers?</td>
<td>__ Yes __ No</td>
</tr>
</tbody>
</table>

**Count the number of “Yeses” for Section C X 3 =**

DSS- 5327 (12/10)
Economic and Family Services
### ADDITIONAL QUESTIONS TO ASK:

**GLASSES:**
Does the client need or wear glasses? Yes __ No __
Last examination was within two years? Yes __ No __

**HEARING:**
Does the client need or wear a hearing aid? Yes __ No __

**MEDICAL/PHYSICAL:**
Has the client experienced any of the following?:
- Multiple, chronic ear infections Yes __ No __
- Multiple, chronic sinus problems Yes __ No __
- Serious accidents resulting in head trauma Yes __ No __
- Prolonged, high fevers Yes __ No __
- Diabetes Yes __ No __
- Severe allergies Yes __ No __
- Frequent headaches Yes __ No __
- Concussion or head injury Yes __ No __
- Convulsions or seizures Yes __ No __
- Long-term substance abuse problems Yes __ No __
- Serious health problems Yes __ No __

Is the client taking any medications that would affect the way he/she is functioning?
Yes __ No __

If yes, what is the client taking? _____________________________
How often? _____________________________________________

Does the client need medical or follow-up services? Yes __ No __

Referrals needed/made:
_________________________________________________________________