Extended Services Statement for SE Stabilization

Clear Form

Individual's Name: _____ CID#: _____

Contractor: _____ DRS Counselor: _____

Employer: _____ Job Title: _____

Please check the box(s) below for the source(s) of extended services that the individual qualifies to receive:

- ☐ Department of Rehabilitation Services for Transition Youth up to age 25
- ☐ Developmental Disability Services of the Department of Human Services (DDS)
- ☐ Natural Supports (Attach Natural Supports & Fading Plan)
- ☐ Private Pay (Individual and/or family)
- ☐ Ticket-to-Work: _____ (Ticket-to-Work Provider)
- ☐ American Indian Vocational Rehabilitation: _____ (Identified Tribal Program(s))
- ☐ Workman's Compensation
- ☐ Other (Please list source(s)): _____

_____

_____

_____

Extended Services Contact Information (ex: DRS Counselor, DDS Case Manager, Employer Natural Support Person(s), Tribal VR Counselor, etc.)

Name: _____

Email: _____

Phone number: _____

Date Extended Services Established: _____

Expected End Date of DRS Supported Employment Services: _____

Other comments:

EC Name: _____ Date: _____