STATE OF RHODE ISLAND
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals
DEVELOPMENTAL DISABILITIES SERVICES
14 Harrington Rd
Cranston, RI 02920
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EMPLOYMENT AND EARNINGS REPORTING FORM

This form is used for the required reporting of earned income and employment changes to BHDDH and Medicaid (Dept of Human Services). You only need to submit it to BHDDH. BHDDH will send it to DHS. The information in this form is used to calculate any income disregards. An Income Disregard allows DHS to exclude part of the income you earn from your job when determining your benefits. Without the income disregard, you may be required to pay a portion of your cost of care. This form will also be used to make referrals for Benefits Planning. Please complete all sections of the form. If you have any questions, please contact your BHDDH social caseworker.

Use this form to report 1) a new job, 2) any change in position, hours, or wages; or 3) when you leave a job.

Please email this form to **BHDDH.ICE@bhddh.ri.gov**. If submitted by an agency, please use **Therap S-Comm**.
Encryption Required if emailed. See the encrypted e-mail instructions on last page.

Please note: This form is used for BHDDH and Medicaid only. If you receive SSI/SSDI, you must report earnings to Social Security directly. If you have other benefits such as subsidized housing, report your income as those programs require.

Name_____ **Submission date**_____

Address_____ **Effective date**_____
of new job, of change, or last date of work

Date of birth_____ **SSN**_____ **Reason for submission** *(check one)*
○ Start job ○ Hour/Wage Change ○ Ended job
○ Request for benefits planning only

Medicaid ID_____

Agency_____ **If Job Ended, Reason for Leaving Job**
_____

❑ **I self direct and this agency is my FI**

1) Employer name_____

2) Employer address_____
Town_____ State_____ Zip code_____

3) Type of paid work *(select one)*
○ Competitive Paid Job ○ Self-Employed ○ Group Supported Employment/Enclave
○ Other_____

4) Is this a job under the Source America (Ability One) federal program? ○ Yes ○ No

5) Job category *(select one from drop down menu)*_____
The job category relates to the job, not the employer industry. For example, a job in a cafeteria in a school would have a job category of "food service", not "education".

6) Title of Position_____

7) Weekly hours worked_____ Hourly wage_____ *(Provide 1 month backup)*

8) Do you want to work more hours per week? ○ Yes ○ No
If yes, how many hours per week do you want to be working?_____

9) Type of BHDDH-funded employment supports provided to the individual for this job *(Check all that apply)*
❑ Job Retention ❑ Job Coaching ❑ Job Transportation ❑ Adaptive Employment Device
Average hours per week of all BHDDH employment supports related to this job_____

Benefits Planning

Why Should I Have Work Incentives Benefits Counseling?

- Work Incentive Benefits Counseling informs you about how earnings impact SSI, SSDI, state benefits, and health insurance.
- It makes you aware of your responsibility for wage reporting.
- This service is available at NO cost toyou.
- If you DECLINE Work Incentive Benefits Counseling now, you may request it in the future.

I hereby certify that I have been offered work incentive benefits counseling services which are intended to help me (and/or my Legal Guardian) understand how employment may affect:

- my disability benefits (SSI, SSDI or other types of Title II benefits, i.e., CDB,DWB)
- my public health insurance benefits (Medicare or Medicaid)
- my SNAP benefits (formerly known as food stamps)
- my rent payment (if I live in subsidized housing)
- other public/private benefits that I may receive.

I understand that Benefits Counseling will provide me with information about various work incentives to which I may be entitled.

I am aware that this service is being offered at no charge to me and that if I decline services, I can request it in the future.

SELECT ONE:

- ❑ I choose to **accept** Benefit Counseling Services. I understand I can stop benefit counseling services at any time. I approve BHDDH, RI DHS and the Sherlock Center to share information for the purpose of confirming state benefits such as Earned Income, SNAP, Medicaid type, Cost share/premium, State Supplement, TANF/Childcare, including Name, Date of Birth and Social Security Number, and follow up communication as needed to address questions as it pertains to providing you benefit counseling services or related issues.
- ❑ **ORS** is providing me with Benefits Planning, so I do not need it through BHDDH.
- ❑ I am getting a benefits plan through **WIPA** grant at The Sherlock Center, so I do not need it through BHDDH.
- ❑ I choose to **decline** Work Incentive Benefits Counseling and have received written information about work incentives. I am choosing to decline because: *(Please check all that apply)*
  - ❑ I have received a Benefits Plan in the past.
  - ❑ I attended a Social Security/WIBC info session.
  - ❑ I believe I understand the impact of employment on my benefits and have sufficient knowledge of the work incentives.
  - ❑ I have been working for some time and understand how wages affect my benefits.
  - ❑ Other: (provide reason for declining services)_____

Individual/Guardian Signature Date Completed

Person Completing Form (please print) Phone Number

Benefits Planning Enrollment Form

This form only needs to be completed if you are requesting benefits planning.

This form will be provided to the Sherlock Center to help them contact you to provide benefits counseling and a benefits plan. To receive a complete analysis of your benefits, you will need to provide information about your federal and state benefits and health insurance to the Benefit Planning Counselor. If someone helps you manage or understand your benefits, we recommend that the person who helps you be involved with the benefits planning. If you have a representative payee for Social Security, it is recommended that the rep payee is also involved.

a. Person to contact to schedule benefits counseling:

Name_____

Phone_____

Email_____

Relationship to DD Participant ❑ Self

❑ Other_____

b. Social Security benefit received ○ SSI ○ SSDI ○ Unsure

c. Why are you requesting benefits counseling? Please list specific questions or concerns.

d. Have you received beneifts counseling before? ❑ No ❑ Yes

If yes, provide name of benefit counselor_____

e. Please describe any accommodations needed to participate in benefits planning, such as support for communication, ASL or language interpreter, etc. Enter "none" if no accommodations are needed.

Internal Use Only Assigned Benefits Counselor:
Notes:

Instructions for Completing the Employment and Earnings Form

- If an individual has more than one employer, a separate form should be completed for each employer.
- The Employment and Earnings Reporting Form should be completed for all individuals for one of the following:
  1. A new job is secured. This includes self employment.
  2. There is a change in the job, such as more/fewer hours, pay raise/decrease, position change, etc.
  3. An individual leaves a job.

In each of the above circumstances, the form should be submitted by the end of the month in which the change occurs. Include copies of pay stubs for that month.
Please note if employment is terminated, the form should be submitted immediately.

FIELD	DESCRIPTION
Name	Name of the person whose information is being submitted
Address, Date of Birth, SSN	Information for the DD participant. Provide the home address, not the mailing address. SSN is needed for benefits counseling.
Medicaid ID Number	The individual identification number on the Medicaid card.
Submission Date	The date that the form is being completed.
Effective Date	The date that employment began, changed, or ended.
Agency	Name of service provider providing employment services or of the fiscal intermediary (FI). If an FI, check the box below the line to indicate the agency is an FI.
Reason for Submission	Select One from the following list: New Job – The individual is beginning a job with a new employer or self employment. Job Change – The individual has a new position with the same employer, has more/fewer hours, has had a pay raise/decrease, etc. Ended Job – Indicates that the individual is no longer working for the reported employer. Requesting Benefits Planning Only – there has been no job change and the form is being submitted only to get benefits counseling.
Reason for Leaving Job	Provide the reason that the individual left employment, such as retired, left for another job, didn't like job, terminated by employer, etc.
Name of Employer	Corporate name of the employer.
Employer Address	The street address with the city, state and zip code of the employer
Type of Work Setting	Please check the box of the type of work setting from the following list: Competitive Paid Individual Job; Self Employment; Group Supported Employment/Enclave; Other
Ability One	Is this a job under the federal Source America (Ability One) program? Yes or No.
Job Category	Please select the type of job that the person has from the following list: Agriculture & Natural Resources, Arts & Communications, Business Administration, Construction, Education & Training, Finance, Government, Health Sciences, Hospitality & Food Service, Human Services, Information Technology, Maintenance & Janitorial, Manufacturing, Public Safety, Retail, Science & Engineering, Transportation & Logistics For example, if the person works in a cafeteria of a University, the job category would be Hospitality & Food Service, not Education & Training.
Title	Title of the position that the individual has or is leaving.
Average Weekly Hours Worked	Typical weekly hours the person works. If there is a range, enter the lower number. For example, if the person works 12-15 hours per week, enter 12.
Hourly Wage	Enter the hourly wage for the job.
Hours Wanted	Enter the hours the individal would ideally like to work each week.
Average Hours per Week of Supported Employment Services Provided	Please round to the closest ¼ hour of supported employment services the individual received for this job at this employer.
Types of Supported Employment Services	Please check the box for each of the services provided: Job Retention (support keeping a job); Job Coaching (support to learn or do the job); Job Transportation (transportation to/ from work); Adaptive Employment Device
Comments	Enter any comments
Signature	Signature of the individual or the individual's guardian.
Date	Date the form is signed.
Person completing the form	Print the first and last name and telephone number of the person completing the form. Enter "self" if completing form for yourself.
Telephone number	Enter the telephone number of the person completing the form.

State of Rhode Island Encrypted Email Instructions

External Users – Composing a Secure Message to State Employee

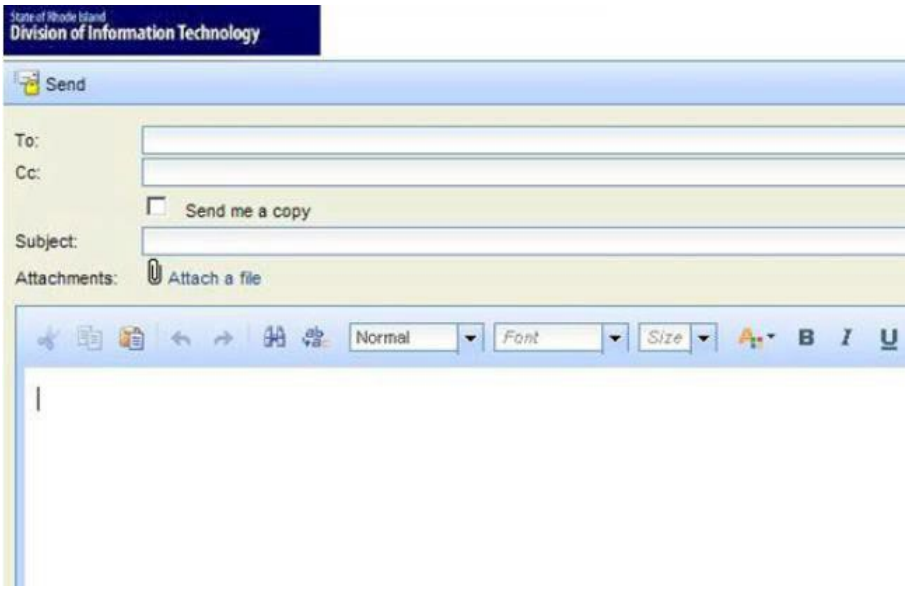
Go to the link https://securemail.ri.gov/securereader/init.jsf?brand=6c656971 you will then be prompted to enter your email address.

If the user has already registered with Proofpoint Encryption, the user will be prompted to provide a password to authenticate before they can compose a secure message.

If the user has not already registered with Proofpoint Encryption, the user is prompted to create an account. The user will then receive a email confirmation to complete the registration process.

Important: For security reasons, registering, authenticating, and composing secure messages with Proofpoint Encryption must be completed in the same browser, on the same system, within a 30-minute period.

Users can compose a message to internal State Employees, as well as attach files to the email. The attachments do not need to be encrypted as the connection between the external user and the State Secure Email Portal is encrypted.



Once message is composed, select Send in the upper left corner. Once the message is sent, you will receive a notice in your browser confirming that the message has been sent.

You can then select New Message to Compose another message or select Logout and close your Proofpoint session.