STATE OF RHODE ISLAND
Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

DIVISION OF DEVELOPMENTAL DISABILITIES
6 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3421
FAX: (401) 462-2775

Employment Add-On Request Form

Please use this form to submit requests for employment services. Attach required documentation.

General Information

Name of Individual: **MID #:**

Date of Birth: **Tier Level:** **Plan Year:**

Agency Providing Employment Services:

Enter Fiscal Intermediary if self-directing employment

CF Case Manager or BHDDH Social Caseworker:

Relationship to individual receiving services:

- ☐ Self
- ☐ Direct Support Professional-Employee
- ☐ Parent or family member
- ☐ Designated Representative
- ☐ Plan Writer
- ☐ Case Manager
- ☐ Support Broker
- ☐ Other Relationship to Individual:

Education

Name of school diploma was received:

Start Date: End Date:

Name of school or program certificate of completion was received:

Start Date: End Date:

Name of school post-secondary education was complete:

Start Date: End Date:

Name of school or program training and certifications were received:

Start Date: End Date:

Vocational & Preparatory Experiences

Include past jobs or other experiences such as internship, volunteering, work-based learning experience, situational assessment, job shadowing, mock interview, information interview, service learning, soft skill development, mentorship, etc. Attach a traditional or visual/pictorial resume if one exists.

Job or Experience Title #1: **Start Date:** **End Date:**

Employer Location:

Describe duties or experiences:

Job or Experience Title #2: **Start Date:** **End Date:**

Employer Location:

Describe duties or experiences:

Job or Experience Title #3: **Start Date:** **End Date:**

Employer Location:

Describe duties or experiences:

Employment Services Request

Check the requested employment services.

☐ Job Development	Amount requested:
☐ Job Coaching	Amount requested:
☐ Job Retention	Amount requested:
☐ Personal Support in the Workplace	Amount requested:
☐ Discovery	Amount requested:
☐ Job Exploration	Amount requested:
	Total amount requested:

Detail how the selected services will help the individual reach their employment goals.

Request Submission

Please submit this completed application and all other supporting documentation with the plan.

Signature of Person Completing Form **Date**

By signing my name above, I attest that the Participant/legal guardian/designated representative has made an informed decision. Note: Completing this form before the participant/legal guardian/ designated representative has made an informed choice is considered falsification of the document.

Signature of Participant **Date**

By signing my name above, I certify that the information on this form and any attached documentation that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge.