State of Utah Department of Workforce Services CONFIRMATION OF EXTENDED SERVICES FUNDING

To be completed by the Extended Services (ES) representative. This form confirms that this individual has funding available for long term support once the individual reaches 20 percent or less coaching intervention OR 24 months on the job.

CLIENT INFORMATION			
Client Name:			
Address:			
City:		ate:	Zip:
Phone: Date of	of Birth:		
Anticipated Extended Services Provider:			
☐ DSPD ☐ DSAMH ☐ Natu	ral Supports] TTW	☐ Private Pay
SECTION 1: To Be Completed for clients eliging Division of Services for People with Disabilities			olicable)
Status with DSPD:			
☐ Waitlist (Support Work Independence Fundamental Control of the	ds) 🗌 Waiver	(Medicaid Fu	unds)
☐ Applicant with DSPD	☐ Not eligi	t eligible for support with DSPD	
Note: Waitlist clients have a SWI worker assigned.	igned while the Wai	ver clients h	nave a Support
Reported DSPD Functional Limitations (Chec	ck all that apply):		
☐ Activities of Daily Life	☐ Capacit	y for Indepe	ndent Living
☐ Communication	n Control of Emotion		
☐ Economic Self-Sufficiency	☐ Employr	ment	
☐ Judgment and Self Protection	☐ Learning	9	
☐ Memory or Cognition	☐ Mobility		
☐ Physical Health	Receptiv	ceptive and Expressive Language	
☐ Self-Care	Self-Dire	ection	
Services receiving from DSPD (For description	n of services go to y	www.dspd.u	tah.gov)
Check all that apply:			
☐ Behavioral ☐ Day Program ☐ Supported Employment ☐ Transportation			
☐ Facility-Based Work (sheltered workshop-	client is receiving su	ub-minimum	wages)
☐ In Home. If yes, provider info:			
Respite Family Support	Supported Livi	ng 🗌 Af	ter School
Residential. If yes, residential info:			
	sional Parent	Supported	Living
Other: Specify:	_		ŭ

Signature of DSPD Representative Ve	rifying Ongoing Funding:		
Signature: /s/	Date:		
Contact Information of Representative			
Email:	Phone:		
SECTION 2: To be completed for clie Division of Substance Abuse and Me	ents eligible for Individual Placement and Support: ental Health Information (DSAMH) (if applicable) or Other rivate pay, SSA work incentive, etc):		
Individual Placement and Support Pro	ovider or OTHER Support Provider:		
Extended supports available:			
Signature of IPS Representative: /s	/ Date:		
Title of Representative:			
Contact Information of Representative	:		
Email:	Phone:		
SECTION 3: To be completed by DS			
Form sent via:	il		
To VR Counselor name:			
Email:			
Fax:	Date sent:		