Extended Services Statement

Clear Form

Individual's Name: _____ Case Number: _____

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
- ☐ 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)): _____

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Other comments:

EC Name: _____ Date: _____