

# Extended Services Statement

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)): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other comments:

EC Name: \_\_\_\_\_ Date: \_\_\_\_\_