



# Supplemental Disclosure Form - Youth

290 North D Street, Suite 600

San Bernardino, CA 92415

(909) 387-9859

NAME (First, Middle Initial, Last): \_\_\_\_\_

LAST FOUR SOCIAL SECURITY NUMBER: \_\_\_\_\_

1.	Are you a pregnant or parenting youth?		Yes	No
2.	Are you a Disabled Veteran?		No Yes, Disabled Yes, Special Disabled (30% or greater)	
3.	Are you receiving Social Security Disability Income (SSDI)?		Yes No	<b>STAFF USE:</b> SS Disability Verification Accepted:
4.	Do you consider yourself to have a disability? (If No, skip to signature)		Yes No	Please Specify Type: Major      Substantial
5.	You are encouraged to voluntarily disclose this information; it will remain confidential and only be used in determining eligibility for services and for equal opportunity records. You will not be penalized if you refuse to answer.		Please specify classification of disability: Physical/Chronic Health Condition      Learning disability Physical/Mobility Impairment      Vision – related disability Mental or Psychiatric Disability      Hearing – related disability Cognitive/Intellectual disability Participant did not disclose type of disability	
6.	Received services from a State Development Disabilities Agency (SDDA)?		SDDA No	Unknown
7.	Received services from a State or Local Mental Health Agency (LSMHA)?		LSMHA No	Unknown
8.	Received services from a Home & Community Based Service Provider under a State Medicaid (HCBS) Waiver?		HCBS No	Unknown
9.	Disability Work Setting:	Sheltered Workshop Not Employed Group Supported Employment Unknown	Competitive Integrated Employment Individual Supported Employment Combination of two or more settings	
10.	Type of customized Employment services received:	Discovery assessment services Employer negotiation services No CES services Unknown	Developed a customized employment search plan Secured employment as a result of receiving customized employment services and received extended support services	
11.	Received disability financial capability:	Benefit planning services No Unknown	Financial capability/asset development services Benefit planning services and financial capability/asset development services	
12.	Section 504 Plan:	Yes      Unknown No	Received services from Vocational Rehabilitation?	Yes      Unknown No

**Customer Certification:** My signature below indicates I have been informed of and understand the information contained on this form. I certify under penalty of perjury, all of the above information is true and complete. I agree any information I have supplied is subject to verification.

SIGNATURE OF CUSTOMER:	DATE	PARENT/GUARDIAN SIGNATURE (If under 18 years old, both Customer and Parent/Guardian must sign form.):	DATE