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**New Jersey Department of Human Services**

**Division of Developmental Disabilities**

 **Employment Determination Form – (F3)**

Developed in Partnership with Division of Vocational Rehabilitation Services (DVRS) and Commission for the

Blind and Visually Impaired (CBVI) for Individuals Eligible for the Division of Developmental Disabilities (DDD).

Completed when someone eligible for DDD is interested in working.

*To Be Completed by the Support Coordinator / DDD Staff Member:*

|  |  |
| --- | --- |
| **Name of Individual:** Click to enter text. | **DDD ID#:** Click to enter text. |
| **Date of Birth:** Click to enter text. | **Last 4 digits of SSN:**  |
| **Date Referral sent to DVRS:** Enter date or N/A | **Date Referral sent to CBVI:**  |

*To Be Completed by the Vocational Rehabilitation (VR) Counselor:*

**The following vocational rehabilitation services are available for this individual at this time:**

[ ]  Trial Work Experience (TWE): End date: Click to enter text.

[ ]  Other Diagnostic Evaluations (specify): Click to enter text.

[ ]  Counseling and Guidance

[ ]  Supported Employment[ ]  Customized Employment[ ]  Work Adjustment training[ ]  (check one)

[ ]  Internship Development[ ]  Apprenticeship & Supports (IDS)[ ]  On the Job Training (OJT)[ ]  (check one)

[ ]  Vocational Certification Training or Post-Secondary College (specify): Click to enter text.

[ ]  Other Assistive Technology assistance: Click to enter text.

[ ]  Individual is not receiving Vocational Rehabilitation services at this time due to the following:

 [ ]  Individual has decided not to apply for services

 [ ]  Order of Selection

 [ ]  Case Closure (indicate date closed): Click to enter text.

 [ ]  Case Transfer (specify agency): Click to enter text.

**Anticipated End Date for Vocational Rehabilitation services (if applicable):** Click to enter a date.

|  |  |
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| Name of DVRS/CBVI Counselor completing this form: | Click to enter text. |
| Office: Click to enter text. | Date: Click to enter a date. |
| Email Address: Click to enter text. | Telephone Number: Click to enter text. |

*To Be Completed by the Support Coordinator / DDD Staff Member and returned by VR Counselor:*

**Please return the completed form to the following Support Coordinator / DDD Staff Member via email.**

|  |  |
| --- | --- |
| Name and Title of Support Coordinator/DDD Staff: | Click to enter text. |
| Email Address: Click to enter text. | Telephone Number: Click to enter text. |