Send completed form to: DDDSPATHWAYS@Delaware.gov ◯ New Castle County ◯ Kent County ◯ Sussex County

DELAWARE HEALTH AND SOCIAL SERVICES
DIVISION OF DEVELOPMENTAL DISABILITIES SERVICES

PATHWAYS TO EMPLOYMENT

Pathways to Employment Application

Date: _____ Referred By: _____ Referrer Contact Info: phone#/email _____

School **and** year expected to exit**:** _____

First Name, Middle Name, Last Name, Suffix: _____

Court Ordered Legal Guardian ◉ *Yes* ◯ *No* (If yes, documentation must be attached)

Parent/Legal Guardian: _____

Living Setting: ☐ Natural Family ☐ Residential Group Home/ Name of Agency _____

☐ Shared Living/ Name of SL Provider _____ Other: _____

Current Address: _____

Contact Phone: _____ Cell Phone: _____ Cell Phone: _____

Email: _____ Date of Birth: _____

Race: _____ Ethnicity: _____ Gender: _____

Would you like to apply for the Pathways to Employment Program? ◯ *Yes* ◯ *No*
Do you want to work? ◯ *Yes* ◯ *No* **Are you currently receiving Medicaid?** ◯ *Yes* ◯ *No*

Applicant Signature: _____ Date: _____

Parent/Legal Guardian
Signature *(if applicable):* _____ Date: _____

****

Office Use Only: ICD 10 Code_____ Aid Category: _____ ◯ Qualifies ◯ Does not Qualify

MCI#: _____ SS#: _____

Division: ◯ **DDDS** ◯ **DVI** ◯ **DSAAPD** ◯ **Non-DDDS**

CN: _____ SC: _____ EN: _____ Other _____

Reviewed by: Name: _____ Date: _____ Date assigned to EN: _____

PTE FORM-001