SAN BERNARDINO COUNTY
Workforce Development

WDD Supplemental Disclosure Form
290 North D Street, Suite 600
San Bernardino, CA 92415
(909) 387-9859

NAME (First, Middle Initial, Last): _____

LAST FOUR (4) DIGITS 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 ***STAFF USE:* SS Disability Verification Accepted:**
4.	**Do you consider yourself to have a disability? (If No, skip to signature section)** ☐ 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 ☐ Physical/Mobility Impairment ☐ Mental or Psychiatric Disability ☐ Vision – related disability ☐ Hearing – related disability ☐ Learning disability ☐ Cognitive/Intellectual disability ☐ Participant did not disclose type of disability
6.	**Received services from a State Development Disabilities Agency (SDDA)?**	☐ SDDA ☐ Unknown ☐ No
7.	**Received services from a State or Local Mental Health Agency (LSMHA)?**	☐ LSMHA ☐ Unknown ☐ No
8.	**Received services from a Home & Community Based Service Provider under a State Medicaid (HCBS) Waiver?**	☐ HCBS ☐ Unknown ☐ No
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