State of Illinois
Department of Human Services - Division of Developmental Disabilities

ALTERNATIVE DAY PROGRAM REQUEST
SUPPORTED EMPLOYMENT - INITIAL AND REVALIDATION QUESTIONNAIRE

Please Complete Online and Print.
This form is REQUIRED for all initial and revalidation requests to authorize Division of Developmental Disabilities (DDD) Supported Employment Program (SEP) codes (36U, 36U & 33U). The form is to be completed by the requesting DDD SEP agency and must accompany the Alternative Day Program Request form (IL462-0285 Revised 09-2021). Please complete a separate SEP Questionnaire for each of the individual's community integrated employers. SEP Requests missing this questionnaire, other information, or signature(s) will be returned as not approved. Authorization, if approved, will be communicated to the SEP agency through an Agency Change Memo and an updated rate sheet.

Individual Served: Last Name: _____ First Name: _____

Requesting SEP Agency Name: _____

Person Completing Request (name & title): _____

Person Completing Request Phone Number: (____) _____ Extension: _____

Person Completing Request E-Mail Address: _____

Type of DDD SEP Initial or Revalidation Requested
If more than one (1) job is held in either or both options, include information on primary employment as applicable for either Integrated and/or Group SEP:

Option 1: DDD SEP Individual (36U)

☐ Initial Request for SEP-I (36U) ☐ Revalidation for SEP-I (36U)

Name of Primary Employer: _____

Employer's Address, Street: _____ City: _____ State: _____ Zip: _____

SEP Supervisor's Name: _____ Title: _____

Individual's Position Title: _____

Individual's Hours Worked Per Month: _____ Hourly Rate of Pay: $ _____

Anticipated hours of SEP Job Coach support needed per month: _____

Does the individual receive benefits with this job? ☐ Yes ☐ No

For **INITIAL** SEP Individual Requests ONLY:

Date of last contact with DRS: _____

Type of DRS Contract Utilized to Obtain Individual's Employment:

☐ Milestone ☐ SEP ☐ CE ☐ N/A ☐ Unknown

Option 2: DDD SEP Group (36G Large (1:6 ratio) and/or 33G Small (1:3 ratio)

☐ Initial Request for SEP-G (36G & 33G) ☐ Revalidation for SEP-G (36G & 33G)

Name of Primary Employer: _____

Employer Address: _____

SEP Supervisor's Name: _____ Title: _____

Individual's Position Title: _____

Individual's Hours Worked Per Month: _____ Hourly Rate of Pay: $ _____

Anticipated hours of SEP Job Coach support needed per month: _____

Has this individual been referred to Department of Rehabilitation Services? ☐ Yes ☐ No

If "Yes", Date(s) of Referral(s): _____

Outcome(s) of Referral(s): _____