DD-403-PF (12-05)
(Refer to A.A.C. R6-6-1504
(Replaces DD-403-A,B,C,D)

ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities
Home and Community Based Services (HCBS)

REFERENCE REQUEST

APPLICANT

This reference request should be provided to a person who has personal knowledge about your employment history, education or character and can attest to your ability to provide services. Two references should be from former/current employers. References **CANNOT** be from family members. Please fill in your name below and give to the person you are requesting a reference from. Instruct the person to mail this Reference Request back to the Division of Developmental Disabilities (DDD).

APPLICANT'S NAME *(Last, First, M.I.)*

APPLICANT'S ADDRESS *(No., Street, City, State, ZIP)*

APPLICANT'S PHONE NO.
( )

PERSON PROVIDING REFERENCE

Please complete the questions listed below keeping in mind that Home and Community Based Services (HCBS) may be performed unsupervised in the home of the person with developmental disabilities or in the residence/facility of the applicant. Your time and effort in completing this form is appreciated and strict confidentiality in regard to your responses will be observed within the provisions of the law.

This reference request **MUST** be returned to the HCBS local office listed on the reverse. If mailing, fold this form in half with the DES/DDD address on the outside, seal lower edge ***(NO STAPLES)***, attach stamp and mail.

PRINT PERSON'S NAME PROVIDING REFERENCE *(Last, First, M.I.)*

ADDRESS *(No., Street, City, State, ZIP)*

DAYTIME PHONE NO.
( )

EVENING PHONE NO.
( )

STATE THE LENGTH OF TIME YOU HAVE KNOWN THE APPLICANT

Years: Months:

TYPE OF ACQUAINTANCE *(Check all that apply)*

☐ Supervised applicant ☐ Worked with applicant ☐ Friend ☐ Neighbor ☐ Other:

INDICATE YOUR FEELINGS ON HOW YOU BELIEVE THE APPLICANT WILL RELATE TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES. DESCRIBE YOUR KNOWLEDGE OF ANY CHARACTERISTICS AND/OR SPECIAL TRAINING/EDUCATION THAT THE APPLICANT MAY HAVE FOR WORKING WITH THESE INDIVIDUALS.

INDICATE IF YOU HAVE ANY REASON TO BELIEVE THAT THE APPLICANT WOULD NOT BE SUITED TO PROVIDE SERVICES TO INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES.

IF THE APPLICANT WAS A FORMER EMPLOYEE, WOULD YOU REHIRE THIS PERSON?

☐ No ☐ Yes ☐ N/A If no, why not?

ADDITIONAL COMMENTS WHICH WILL HELP IN EVALUATING THIS APPLICANT

PERSON'S SIGNATURE PROVIDING REFERENCE

DATE

FOR OFFICE USE ONLY

INTERVIEWED BY PHONE

☐ No ☐ Yes

DATE

PRINT INTERVIEWER'S NAME *(Last, First, M.I.)*

INTERVIEWER'S SIGNATURE

Equal Opportunity Employer/Program ♦ Under Titles VI and VII of the Civil Rights Act of 1964, and the Americans with Disabilities Act of 1990 (ADA), Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, the Department prohibits discrimination in admissions, programs, services, activities, or employment based on race, color, religion, sex, national origin, age, and disability. The Department must make a reasonable accommodation to allow a person with a disability to take part in a program, service or activity. For example, this means if necessary, the Department must provide sign language interpreters for people who are deaf, a wheelchair accessible location, or enlarged print materials. It also means that the Department will take any other reasonable action that allows you to take part in and understand a program or activity, including making reasonable changes to an activity. If you believe that you will not be able to understand or take part in a program of activity because of your disability, please let us know of your disability needs in advance if at all possible. To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at (602) 542-6825; TTY/TTD Services: 7-1-1.

Fold Here

RETURN ADDRESS

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Place Stamp Here

Division of Developmental Disabilities
HCBS _____

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Tape Here