DDD-0403A FORFF (9-19)
(Refer to A.A.C. R6-6-1504)
(Replaces DD-403,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 Phone No. ____________

Applicant's Address *(No., Street)* ______________________

City ______________________ State ________ ZIP Code ____________

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 Code ____________

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? Yes No

Additional Comments Which Will Help In Evaluating this Applicant

Person's Signature Providing Reference ______________________ Date ____________

FOR OFFICE USE ONLY

Interviewed by Phone Yes No Print Interviewer's Name (Last, First, M.I) ______________________

Interviewer's Signature ______________________ Date ____________

See page 2 for EOE/ADA disclosures

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities Customer Service Center at 1-844-770-9500; TTY/TDD Services: 7-1-1 • Disponible en español en línea o en la oficina local

Fold Here

Return Address

____

____

____

Division of Developmental Disabilities

HCBS ___________________________

____

____

Tape Here