BRIDGES PROGRAM

"Your service bridge from school to work"

WHY?

Preparing for life after the school bus stops coming is crucial for individuals with developmental disabilities and their families. Often, this planning is left until the last minute and young adults are left without supports and services which can lead to feelings of isolation and unproductivity. Not to mention the concern you may face about how that individual will receive support during the time when they would typically be at school.

Students become eligible for long-term employment services once they graduate and turn 22. By participating in the Bridges Program you can ensure that your adult child is prepared for life after their transition program.

WHO?

- Must be a Developmental Disabilities Administration (DDA) client or willing to apply for DDA services. A student may receive Bridges services while their application is processing and eligibility is being determined at DDA. **If deemed ineligible, the student will no longer receive Bridges services.**
- Must be a Skagit County resident who is 18-22 years old
- Must be a student who is enrolling in a current transition program (ATTIC or INVEST)

WHAT?

Bridges is a program to prepare students with developmental disabilities to get a job by the time they graduate from their transition program at age 22. Bridges connects students to supports and services that will benefit them as they move from school-based services to employment and independence. Students will work with their selected provider on a regular basis.

Program services are individualized to meet the student's needs and may include:

- Assistance in completing eligibility paperwork for adult service providers, including:
  - Social Security/Supplemental Security Income (SSI)
  - Developmental Disabilities Administration (DDA)
  - Department of Vocational Rehabilitation (DVR)
- Person-Centered Planning: gathers assessment information to help the student develop job goals
- Paratransit Application and Travel Training with Skagit Transit
- Guardianship Information
- Technology Access Information
- Assistance in applying for EBT/Food Stamps
- Assistance in applying for WA State ID

Bridges Services do not include:

- Job development/placement*
- Job coaching*

**These services are provided by DVR or the school district and the County cannot duplicate services.*

WHEN?

Students will receive Bridges services for the duration of their transition program. Bridges services will be provided simultaneously as the student's transition program, but outside of the hours a student is attending their transition program. Bridges services can be scheduled at a time that works for YOU.

Applications will be accepted up until November 1st of the 3rd year of transition.
Contact Jen Smith, Transition Specialist, with questions (360) 416-1520.

WHERE?

Bridges services can happen in a variety of locations depending on your preference and what is convenient for your family. Bridges services will be delivered in a variety of ways including in person and remotely (virtual meetings, phone calls, etc.). We will do what is comfortable for your family.

HOW?

To participate in the Bridges Program, you will need to complete a few steps:

1. Complete an eligibility application.
   Call to request the application be mailed to you or print the application off our website:
   https://www.skagitcounty.net/Departments/HumanServices/DD/transition.htm

2. Review and sign the DSHS Consent forms in the application packet- this allows all system partners to communicate about the student's progress in the Bridges Program and needs for future success.

3. Complete the provider selection form in the packet. We recommend connecting with each provider to conduct a brief interview before deciding which one you would prefer to work with.

4. Submit your application, consent form, and provider selection form to Jen Smith by scanning and emailing to jrsmith@co.skagit.wa.us or by mailing it to:
   Developmental Disabilities Program
   C/O Skagit County Public Health
   301 Valley Mall Way, Suite 110
   Mount Vernon, WA 98273

5. After you are accepted to the Bridges program you will hear from your Employment Service Provider of choice to set up an intake meeting, as well as a Person-Centered Planner to schedule a meet-and-greet.

Please note: We will continue with Bridges services while a student is applying for DDA, if deemed ineligible, the student will no longer receive Bridges services.

Developmental Disabilities Program
2024-25 Bridges Application

Date		School District		Teacher's Name	
SKAGIT COUNTY RESIDENT?	☐ Yes ☐ No	*Skagit County Residency Required*			

Student's Name: _____
Last Name First Name Middle Initial

Address: _____
Street City Zip Code

Contact: _____
Home Phone Cell E-Mail

Own Legal Guardian? ☐ Yes ☐ No

PRIMARY CONTACT / GUARDIAN / SUPPORT PERSON: **(Must include guardian if student is not own guardian)**

Name	Relationship to student	Primary Phone	E-Mail Address

DEMOGRAPHIC INFORMATION

BIRTHDATE: _____
Month Day Year

GENDER: ☐ Male ☐ Female ☐ Other

RACE: _____ **ETHNICITY:** _____

DDA INFORMATION

DDA Status: (√ all that apply)

☐ **Have Case/Resource Manager / NAME:** _____
☐ **No Case/Resource Manager**
☐ **Basic Plus Waiver**
☐ **CIIBS Waiver**
☐ **IFS Waiver**
☐ **State Supplemental Payment (SSP)**
☐ **Applying / Reapplying / Appealing**
☐ **Core Waiver**
☐ **Community Protection**
☐ **Community First Choice Option**
☐ **Unsure about DDA Status**

STUDENT LIVING SITUATION

Who do you live with now? (√ all that apply)

☐ **Alone / Self Only**
☐ **Parent(s)**
☐ **Friends or other relatives**
☐ **Adult family home**
☐ **Supported living (VOA Rehabco)**
☐ **Partner/spouse**
☐ **Homeless**
☐ **Foster parents**
☐ **Sibling(s)**
☐ **Detention**
☐ **Shelter**

EDUCATIONAL STATUS

Are you currently attending school? ☐ Yes ☐ No

Name of School / School Program: _____

Exit year: _____

DSHS/DVR INFORMATION

Have you applied to DVR? ☐ Yes ☐ No

DVR Counselor's name? _____

☐ **Interpreter needed?** ☐ **Yes** ☐ **No**

Language: _____

ASL: _____

Other: _____

SOCIAL SECURITY BENEFITS & INCOME (√ all that apply)

SSI / MEDICAID BENEFITS ☐ Yes ☐ No

SSDI / CDB (DAC) / MEDICARE BENEFITS ☐ Yes ☐ No

Is the student employed? ☐ Yes ☐ No

If so, how much is the student earning monthly? $_____

Developmental Disabilities Program

2024-25 Bridges Application

Participant Agreement

By participating in the program I agree to (Put an X next to all that apply):

- ☐ Complete required paperwork with chosen employment agency (with assistance if needed)
- ☐ Work with the Employment Specialist to complete applications for DDA, DVR, and benefits from Social Security
- ☐ Complete and sign attached DSHS consent to allow agency communication
- ☐ Continue to participate in my school program and IEP goals
- ☐ Maintain appointments and communicate regularly with the employment specialist and other providers helping me in the Bridges program
- ☐ Participate in any reviews needed to determine eligibility for a paid service (DDA/DVR)
- ☐ Obtain benefits planning services as part of the DVR process

Please note that new Bridges applications will be accepted up until November 1st of the student's 3rd year of transition.

I have read the eligibility requirements and program responsibilities above and agree to participate in the Skagit County Bridges Program. I understand that participation in the Bridges Program does not guarantee me access to the state-funded long-term support program. I understand that I may receive Bridges services while my application is being processed and eligibility is being determined by DDA, but if I am deemed ineligible for DDA services, I will no longer receive Bridges Services.

_____ _____

Student Signature *Date*

_____ _____

Guardian Signature (when applicable) *Date*

Washington State Department of Social & Health Services

CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☐ Health care providers: _____
- ☐ Mental health care providers: _____
- ☐ Chemical dependency service providers: _____
- ☒ Other DSHS contracted providers: **DDA, Skagit County Public Health DD Program, Dreamcatcher Facilitation**
- ☐ Housing programs: _____
- ☒ School districts or colleges: **School District/ High School Transition Program, SVC INVEST Program, WVS ATTIC Program**
- ☐ Department of Corrections: _____
- ☐ Employment Security Department and its employment partners: _____
- ☐ Social Security Administration or other federal agency: _____
- ☐ See attached list
- ☒ Other: **Chinook Enterprises, Sherwood Community Services, Work Opportunities**

I authorize and consent to sharing the following records and information (check all that apply):

- ☐ All my client records
- ☐ Records on attached list
- ☐ Only the following records
  - ☒ Family, social and employment history
  - ☐ Payment records
  - ☒ Health care information
  - ☒ Individual assessments
  - ☒ Treatment or care plans
  - ☒ School, education, and training
  - ☐ Other (list): **Information needed to establish & assist w/eligibility & transition services w/ the school district, DDA, DVR, & contracted vocational providers to address the student's post graduate employment goals.**

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Chemical Dependency (CD) services

- **This consent is valid for ☐ one year ☐ as long as DSHS needs records, or ☒ until Exit From School District (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Washington State Department of Social & Health Services

CONSENT

NOTICE TO CLIENTS: The Department of Social and Health Services (DSHS) can help you better if we are able to work with other agencies and professionals that know you and your family. By signing this form, you are giving permission for DSHS and the agencies and individuals listed below to use and share confidential information about you. DSHS cannot refuse you benefits if you do not sign this form unless your consent is needed to determine your eligibility. If you do not sign this form, DSHS may still share information about you to the extent allowed by law. If you have questions about how DSHS shares client confidential information or your privacy rights, please consult the DSHS Notice of Privacy Practices or ask the person giving you this form.

CLIENT IDENTIFICATION:

NAME	DATE OF BIRTH	IDENTIFICATION NUMBER

ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE NUMBER (INCLUDE AREA CODE)	OTHER INFORMATION

CONSENT:

I consent to the use of confidential information about me within DSHS to plan, provide, and coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. I further grant permission to DSHS and the below listed agencies, providers, or persons to use my confidential information and disclose it to each other for these purposes. Information may be shared verbally or by computer data transfer, mail, or hand delivery.

Please check all below who are included in this consent in addition to DSHS and identify them by name and address:

- ☐ Health care providers: _____
- ☐ Mental health care providers: _____
- ☐ Chemical dependency service providers: _____
- ☒ Other DSHS contracted providers: **Division of Vocational Rehabilitation (DVR)**
- ☐ Housing programs: _____
- ☐ School districts or colleges:
- ☐ Department of Corrections: _____
- ☐ Employment Security Department and its employment partners: _____
- ☐ Social Security Administration or other federal agency: _____
- ☐ See attached list
- ☐ Other:

I authorize and consent to sharing the following records and information (check all that apply):

- ☐ All my client records
- ☐ Records on attached list
- ☐ Only the following records
  - ☒ Family, social and employment history
  - ☐ Payment records
  - ☒ Health care information
  - ☒ Individual assessments
  - ☒ Treatment or care plans
  - ☒ School, education, and training
  - ☐ Other (list): **Information needed to establish & assist w/eligibility & transition services w/ the school district, DDA, DVR, & contracted vocational providers to address the student's post graduate employment goals.**

PLEASE NOTE: If your client records include any of the following information, you must also complete this section to include these records.

I give my permission to disclose the following records (check all that apply):

☐ Mental health ☐ HIV/AIDS and STD test results, diagnosis, or treatment ☐ Chemical Dependency (CD) services

- **This consent is valid for ☐ one year ☐ as long as DSHS needs records, or ☒ until Exit From School District (date or event).**
- **I may revoke or withdraw this consent at any time in writing, but that will not affect any information already shared.**
- **I understand that records shared under this consent may no longer be protected under the laws that apply to DSHS.**
- **A copy of this form is valid to give my permission to share records.**

SIGNATURE	DATE	AGENCY CONTACT/WITNESS SIGNATURE	DATE

PARENT OR OTHER REPRESENTATIVE'S SIGNATURE (IF APPLICABLE)	TELEPHONE NUMBER (INCLUDE AREA CODE)	DATE

If I am not the subject of the records, I am authorized to sign because I am the: (attach proof of authority)

☐ Parent ☐ Legal Guardian (attach court order) ☐ Personal representative ☐ Other:

NOTICE TO RECIPIENTS OF INFORMATION: **If these records contain information about HIV, STDs, or AIDS, you may not further disclose that information without the client's specific permission.** If you have received information related to **drug or alcohol abuse** by the client, you must include the following statement when further disclosing information as required by 42 CFR 2.32:

> This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medial or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

INSTRUCTIONS FOR COMPLETION OF CONSENT FORM

Purpose: Use this form when you need consent to use confidential information on a continuing basis about a client within DSHS or to disclose that information to other agencies to coordinate services or for treatment, payment or agency operations or for other purposes recognized by law. Clients are persons receiving benefits or services from DSHS.

Use: Fill out this form electronically if possible for ease of reading, **A separate form must be completed for each person, including children.** "You" in the instructions refers to the DSHS employee and "you" on the form refers to the client. Sharing of records includes the use and disclosure of confidential information about a client.

Parts of Form:

IDENTIFICATION:

- Name: Provide the name of one client only on each form. Include any former names that client may have used when receiving services.
- Date of Birth: Needed to identify client from persons with similar names.
- Identification Number: Provide a client identification number or other identifier such as a social security number (not required) to assist in identifying records and tracking history and services received.
- Address and telephone: Additional information that will help in locating and identifying or contacting the client.
- Other: Include in this box any additional information that may help to locate records that may include parts of DSHS involved with services, names of family members, or other relevant information.

CONSENT (AUTHORIZATION):

- Agencies or persons exchanging records: The client's completion of this form allows the use and sharing of confidential information within all of DSHS. DSHS will be able to disclose to and receive confidential information from the outside agencies or persons listed. Provide identifying information about the agencies or providers, including name, address or location if possible. You may also attach a list of agencies allowed to share information which the client must also sign.
- Information included: Clients must indicate what records are covered by the consent. Clients may make all records available or may limit the included records by date, type or source of record. If a client does not sign a consent or does not specify a particular record, sharing of that record will still be allowed if permitted by law. You may attach a list of covered records that the client must also sign. If any records include information relating to mental health (RCW 71.05.620), HIV/AIDS or STD testing or treatment (RCW 70.24.105), or drug and alcohol services (42 CFR 2.31(a)(5)), the client must mark these areas specifically to give permission to share these records. This form is not valid to include psychotherapy notes under 45 CFR 164.508(b)(3)(ii) and a separate form must be completed to include those records.
- Duration: Include an expiration date for the consent that serves your program purposes or as provided by law.
- Understanding: Be sure the client understands what permission is being granted and how and why information will be shared. If needed, use a translated form and interpreter or read the form aloud. If the client needs more information, provide an additional copy of the DSHS Notice of Privacy Practices or refer the client to the public disclosure officer for your unit

SIGNATURES:

- Client: Have client or a child over age of consent (13 for mental health and drug and alcohol services; 14 for HIV/AIDS and other STDs; any age for birth control and abortions; 18 for health care and other records) sign this box and insert the date of signature. The client may substitute a mark in this box that you witness.
- Agency Contact or Witness: You will sign in this box if you are the one presenting and explaining the form to the client. Please include your telephone number. If the client will be signing the form away from a business site, instruct the client to have a witness sign in this block and provide a telephone number. A notary public may serve as a witness to a client signature.
- Parent or Other Representative: If the client is a child under the age of consent, a parent or guardian must sign. If the child does not meet the age of consent for all records to be shared, both the child and the parent must sign. If the client has been declared legally incompetent, the court appointed guardian must sign and provide a copy of the order of appointment. If someone is signing in another capacity (including a person with a power of attorney or an estate representative), mark "other" and obtain a copy of the legal authority to act. The person signing must date the signature and give a telephone number or contact information.

DVR Brief Intake Form

900 E College Way, Suite 120, Mount Vernon, WA 98273

(360) 429-3097 - DVRMountVernonOnlineReferral@dshs.wa.gov

Date | First Name | Middle Name | Last Name

Preferred Name | Date of Birth | Social Security #

Primary Phone # | Secondary Phone # | Email Address

Mailing Address

City | State | ZIP Code

Address Type
(Home, School, Temp, Work, Other, Mailing)

Residence Type
(Private, Correctional, Halfway House, Homeless, MH Facility, Nursing Home, Rehab Facility, Substance Use Treatment Center)

Preferred Contact Method | Gender and Pronouns

Primary Preferred Language | Accommodation Needs/Translation Needs

Disabilities & Barriers to consider (please give details):

What would you like from DVR?

I-9 Documents: Yes ☐ No☐

Previous Customer: Yes ☐ No☐

Referred by | DVR Staff Name

Tribal Affiliation: Yes ☐ No☐

Medicare: Yes ☐ No☐ Medicaid: Yes ☐ No☐

Do you receive public benefits or services such as Social Security or EBT: Yes ☐ No☐

BRIDGES

SKAGIT COUNTY PUBLIC HEALTH

Please indicate which provider you'd prefer to enroll with for the Bridges Program*

Please make sure you include this form when returning your application packet

☐ Chinook Enterprises
(360) 428-0140
rsilva@chinookenterprises.org

☐ Sherwood Community Services
(425) 367-2056
lraitz@sherwoodcs.org

☐ Work Opportunities
(425) 280-1369
hannahv@workopportunities.org

*Please be aware that we will do the best we can to enroll you with the provider you prefer but may need to adjust this choice due to capacity. If this change is necessary, we will communicate with you before starting your Bridges services.

Updated 6/8/23

CHINOOK enterprises

WHERE ABILITY MEETS OPPORTUNITY

We believe everyone needs a place to connect and contribute; To feel valued and appreciated. For most of us, that means a job.

Who We Are

We are a non-profit with a social mission to support full participation in community life for people with disabilities or other barriers. We believe full participation starts with successful employment and we're here to help you navigate this transition and take charge of your future.

Celebrating 40 years

For over 40 years, we have made it our priority to be actively involved in our community through partnerships with our customers and the businesses of Skagit County. Our staff offers a wide range of educational and professional backgrounds to provide you with the best service possible to help you achieve your goals.

Person Centered

We thrive on helping you chart your course to success.

Customized

Use us as your compass to uncover valuable resources.

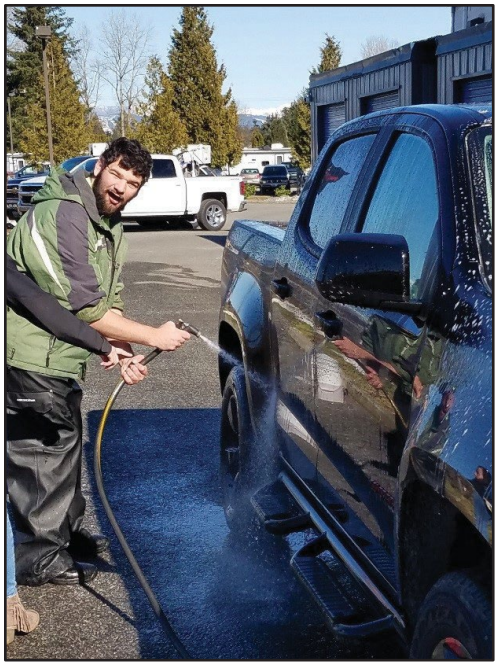
Planning

We're here to support you every step of the way.

SCAN ME

360-428-0140

Email : info@chinookenterprises.org
Website : www.ChinookEnterprises.org
Address : 2026 N. LaVenture Rd. Mount Vernon, WA 98273
facebook.com/chinookenterprises.getjobs



Vocational Services

Did you know that nationally, only about 20% of people with disabilities are employed?

Don't be a part of the 80%!

Let Sherwood support your family to achieve employment **BEFORE** graduation.

Talk to your student's teacher about the **Bridges Program** and how it can help set your student up for success in employment.

There is a lot to do to get ready for adult life.

Sherwood can help!

Sherwood's highly trained and experienced Employment Specialists will help you **nagivate** the world of supports that take over after the school years are complete.

Partnering with Sherwood for the **Bridges Program** will help set you up to join the **100%** of students who have graduated from our school to work program with paid employment.

SHERWOOD
Believing in Abilities

Innovative, inclusive services for children and adults with disabilities in their communities.

Talk to your teacher or contact us today:

Lindsay Raitz
Lraitz@sherwoodcs.org
425-367-2056
2021 E College Way Suite 112
Mount Vernon, WA 98273

www.sherwoodcs.org

Find us on Facebook: www.facebook.com/SherwoodCommunityServices

WORK OPPORTUNITIES

Work Opportunities is a non-profit agency that has been providing employment support for the last *60 years* to people experiencing disabilities in Western Washington State.

An Employment Specialist (also known as a job coach) will provide one-on-one, individualized support on your employment journey.

How Can We Help?

- **Job Search Training**
- **Interview Skills Practice**
- **Advocacy with Employers**
- **Creating Marketing Materials**
  - **Resume (paper or video)**
  - **Cover Letter**
  - **Employment Proposal**
- **On-The-Job Training**
- **Social Skills Coaching**
- **Customized Employment**
- **Person-Centered Planning**
- **Accommodation Building**
- **Encouraging Independence**

... and *so* much more!

Want More Info? Contact Us!

Hannah Voss, Assistant Manager
(425)-280-1369
hannahv@workopportunities.org

The mission of Work Opportunities is to promote self-determination, self-respect, and valued participation in the community for people with disabilities through work.

Check out our website!
www.workopportunities.org

Watch our stories on Vimeo!

INTERVIEW AND CHOOSE AN EMPLOYMENT PROVIDER

Providers are qualified agencies that contract directly with Skagit County to provide Bridges Services and ultimately Career Path Services (Employment and Community Inclusion). Providers have expertise in supporting individuals with employment goals. We recommend you give the providers a call and set up a choice interview to help in the decision-making process. As you interview different providers, share your ideas, and ask how they can support you to achieve your career path goals

The Providers:

Chinook Enterprises	Sherwood Community Services	Work Opportunities
Renee Silva	Lindsay Raitz	Hannah Voss
(360) 428-0140	(425) 367-2056	(425) 280-1369
rsilva@chinookenterprises.org	lraitz@sherwoodcs.org	hannahv@workopportunities.org

Here are some sample questions to help you get started:

- □ I am interested in a job in the following locations or areas of vocational expertise _____. Do you have connections in these areas? How would you assist me?

- □ I have limited work experience and I am not sure what I want to do. How would you help me explore my options?

- □ What will be MY role in finding a job? What is YOUR role in helping me find a job?

- □ Do you support other folks in my community? What kind of connections do you have with companies in the area in which I live?

- □ How can you assist me with transportation?

- □ How many people does your agency serve? How many other people will my job coach be supporting? How often can I expect to see my job coach?

- □ How will you keep communication open with me, my parents, guardians, and significant others? (Email, phone, text, or written)

- □ How would you help me if I have special needs such as: medication, personal care, cultural diversity, behavior or communication challenges, or safety issues?

- □ Can you share information about your successes with job placement and /or a creative story?