

Self-Directed Employee Status and Hourly Rate Request

Consumer Name: _____

DDD: _____

Self-Directed Employee Information

SDE First Name	SDE Last Name	SDE Email	SDE Phone #	Proposed # Of Weekly Hours	Proposed Hourly Rate	Billable Rate (AwC use only)
1.					\$	\$
2.					\$	\$
3.					\$	\$
4.					\$	\$
5.					\$	\$
6.					\$	\$
7.					\$	\$
8.					\$	\$
9.					\$	\$
10.					\$	\$

Please complete the table below if your staff has a certification of the following trainings and if the staff will perform any of the following tasks.

SDE Name	CPR certified If yes provide expiration date.			First Aid certified If yes provide expiration date.			Will the staff administer medication?		Will the staff provide transportation?		Transportation Rate (There is no gas or mileage reimbursement)	Billable transportation rate (AwC use only)
	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No		
1.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
2.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
3.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
4.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
5.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
6.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
7.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
8.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
9.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$
10.	Yes	No	Exp	Yes	No	Exp	Yes	No	Yes	No	\$	\$

Will you be using a support a Support Broker?

First Name	Last Name	Phone Number	Email

Consumer/Managing Employer Signature: _____ Date: _____

Confirm consumer email: _____

Please return this completed form to our Customer Service Team at: awccustomerservice@nj.easterseals.com Any delay in sending this form will result in a delay in transitioning into Agency with Choice Program.