OMB Control No.: 1230-0014
Expiration date: 05/31/2022

[STATE NAME] RETAIN Project

Retaining Employment & Talent after Injury/Illness Network

Participant Enrollment Information Form: Part One
TO BE COMPLETED BY PARTICIPANT

ALL FIELDS REQUIRED

1. **Full Name**

_____
FIRST MIDDLE LAST

2. **Mailing Address:**

_____
STREET (OR P.O. BOX) CITY STATE ZIP

3. **Email address:**

_____@_____

4. **Phone Number:**

|___|___|___| - |___|___|___| - |___|___|___|___|

5. **Date of Birth:**

|___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

6. **Social Security Number:**

|___|___|___| - |___|___| -|___|___|___|___|

7. What language do you prefer to communicate in?

MARK ONE ONLY

- ☐ English
- ☐ Spanish
- ☐ Other language *(please specify)*

_____

8. What is your sex?

MARK ONE ONLY

- ☐ Male
- ☐ Female

9. Are you of Hispanic, Latino, or Spanish origin?

MARK ONE ONLY

- ☐ Yes
- ☐ No

10. What is your race?

MARK ALL THAT APPLY

- ☐ White
- ☐ Black or African-American
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Hawaiian or Pacific Islander

11. What is your highest level of educational attainment?

MARK ONE ONLY

- ☐ Less than a high school diploma
- ☐ High school diploma, GED or certificate of completion
- ☐ Occupational certificate/license or 2-year college degree
- ☐ 4-year college degree (bachelor's degree)
- ☐ Post-graduate degree (master's, doctorate, professional)

12. Do you currently have an injury or illness that limits the kind or amount of work you can do?

- ☐ Yes
- ☐ No

13. In general, would you say your current health is?

MARK ONE ONLY

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor

14. In the last 12 months, did you work at a job that paid you more than $1,000 a month (before taxes and deductions)?

- ☐ Yes
- ☐ No

15. What best describes your current employment status…

MARK ONE ONLY

- ☐ Not employed
- ☐ Self-employed
- ☐ Employed at private company, non-profit, or government

16. How many hours per week did you usually work before your injury/illness?

_____

17. How long has it been since you last worked?

MARK ONE ONLY

- ☐ I worked today
- ☐ No more than a week ago
- ☐ More than a week ago but no more than a month ago
- ☐ More than a month ago but no more than three months ago
- ☐ More than three months ago but no more than six months ago
- ☐ More than six months ago

18. How long have you been continuously employed at your current job (or most recent job, if not currently employed)?

- ☐ No more than 6 months
- ☐ More than 6 months but no more than 1 year
- ☐ More than 1 year but no more than 2 years
- ☐ More than 2 years but no more than 5 years
- ☐ More than 5 years

19. Within the last 3 years, did you <u>apply for</u> or <u>receive</u> disability benefits from the Social Security Administration --- either Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI)?

- ☐ Yes
- ☐ No

20. Have you ever served on active duty in the U.S. Armed Forces, Reserves, or National Guard?

- ☐ Yes
- ☐ No

21. Are you now covered by any of the following types of health insurance?

MARK ALL THAT APPLY:

a. Private insurance plan through own employer	☐
b. Private insurance plan through family member's employer	☐
c. Private insurance plan not connected to any employer	☐
d. Medicare	☐
e. Medicaid	☐
f. Veteran's Health Plan	☐
g. Other *(please specify)* _____	☐

22. Are you currently receiving income from any of the following sources?

MARK ONE PER ROW

	YES	NO	DON'T KNOW
a. Social Security disability (SSDI or SSI)?	☐	☐	☐
b. Veterans' benefits?	☐	☐	☐
c. Workers' compensation?	☐	☐	☐
d. Employer-provided or other private disability insurance?	☐	☐	☐
e. Other public programs *(specify)*			☐

MARK ONE PER ROW

	YES	NO	DON'T KNOW
_____	☐	☐	

Thank you for completing this form. Please return it to xxxx. If you have any questions, please contact xxxx.

Public reporting burden for this collection of information is estimated to average 10 minutes per respondent. Send comments concerning this burden estimate or any other aspect of this collection of information to the U.S. Department of Labor, Office of Disability Employment Policy, Room S-1313, Constitution Ave., Washington, DC 20210. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a valid OMB control number. (Paperwork Reduction Act OMB Control Number, 1230-0014.)

Privacy Act Statement
Collection and Use of Personal Information

The following statement is made in accordance with the Privacy Act of 1974 (5. U. S. C. 552a). Information collected will be handled and stored in compliance with the Freedom of Information Act and the Privacy Act of 1974, as amended (5 U.S.C. 552a). Furnishing us this information is voluntary. However, failing to provide all or part of the information will prevent you from participating in the RETAIN demonstration project.

We will use the information you provide for the RETAIN project. Disclosure of information from this system of records will be made to the Social Security Administration and a third party organization under contract to the Social Security Administration for the performance of project management activities directly related to this system of records. The United States Department of Labor, Office of Disability Employment Policy and its employees will use the information you provide in de-identified format for statistical purposes only and will hold the information in confidence to the full extent permitted by law. In accordance with the Confidential Information Protection and Statistical Efficiency Act of 2002 (Title 5 of Public Law 107-347) and other applicable Federal laws, your responses will not be disclosed in identifiable form without your informed consent. Per the Federal Cybersecurity Enhancement Act of 2015, Federal information systems are protected from malicious activities through cybersecurity screening of transmitted data.