Form Approved
OMB No. 0960-0282

DEVELOPMENT OF PARTICIPATION IN A VOCATIONAL REHABILITATION OR SIMILAR PROGRAM

Part I - To be completed by the State DDS or SSA Field Office

Section A - Beneficiary Information

1. Beneficiary' s Name (Last, First, MI)

2. Beneficiary's Date of Birth

3. Type of claim

☐ DI ☐ SSI ☐ Concurrent

4. Beneficiary's Social Security Number

\- -

5. Wage Earner's Social Security Number (if different from Beneficiary's)

\- -

6. Beneficiary's address (Number & Street, City, State, Zip Code)

7. Beneficiary reports that he/she is receiving vocational rehabilitation services, employment services, or other support services from (check one):

_____ **An Employment Network under an Individual Work Plan (IWP)**

_____ **A State Vocational Rehabilitation agency under an Individualized Plan for Employment (IPE)**

_____ **Other provider of services under an individualized, written employment plan similar to an IPE**

_____ **An educational institution under an Individualized Education Program (IEP) to beneficiary age 18 through 21 years**

8. Name, address and telephone number of a contact person in the organization/agency identified above:

Section B - DDS/FO Information

9. Signature of Person Who Completed Part I:

10. Title:

11. Date:

12. DDS or FO Code:

13. Telephone number (include area code): ( ) -

Part II - To be completed by provider/coordinator of services as shown below

Section A - Employment Network
Section B - State Vocational Rehabilitation Agency
Section C - Other provider of vocational rehabilitation services, employment services, or other support services (If not an agency of the Federal Government or not an educational institution administering a student plan in accordance with the Individuals with Disabilities Act, attach a copy of qualifications to provide vocational rehabilitation services in State services are provided, i.e., license, certification, accreditation, or registration.)
Section D - Educational Institution under IDEA

Section A -To be completed by Employment Network

1. Is the beneficiary receiving vocational rehabilitation services, employment services, or other support services under an Individual Work Plan (IWP)? ☐ Yes ☐ No
   If no, sign below and return this document to requester.
   If yes, give the date the beneficiary and EN signed the IWP and proceed to next question.
   Date IWP signed:
2. Is the beneficiary taking part in the activities and services outlined in the IWP? ☐ Yes ☐ No
   If no, sign below and return this document to requester. If yes, proceed to next question.
3. What is the employment goal?
4. Describe the education, work skills, and/or work experience that the beneficiary will acquire by completing the IWP or by continuing to participate in the IWP for a specified period of time.
5. When is the beneficiary expected to complete the activities and services outlined in the IWP? (Month and Year) :

Signature: Date:

Title: Telephone No. (include area code): ( ) -

Section B - To be completed by the State Vocational Rehabilitation (VR)

1. Is the beneficiary receiving VR services, employment services, or other support under an Individualized Plan for Employment (IPE)? ☐ Yes ☐ No
   If no, sign below and return this document to requester.
   If yes, give the date the beneficiary and the VR Counselor signed the IPE and proceed to next question. Date IPE signed:
2. Is the beneficiary taking part in the activities and services outlined in the IPE? ☐ Yes ☐ No
   If no, sign below and return this document to requester. If yes, proceed to next question.

3 What is the employment goal?

4. Describe the education, work skills, and/or work experience that the beneficiary will acquire by completing the IPE or by continuing to participate in the IPE for a specified period of time.

5. When is the beneficiary expected to complete the activities and services outlined in the IPE? (Month and Year) :

Signature: Date:

Title: Telephone No. (include area code): ( ) -

Section C - To be completed by Another Provider of Rehabilitation Services

If you are not an agency of the Federal Government or not an educational institution under the Individuals with Disabilities Act (IDEA), attach a copy of your qualifications to provide vocational rehabilitation services, employment services or other support services in the State in which you are providing the services (i.e., license, certification, accreditation, or registration).

1. Is the beneficiary receiving vocational rehabilitation services, employment services or other support services under an individualized, written employment plan similar to an Individualized Plan for Employment used by State Vocational Rehabilitation Agencies? ☐ Yes ☐ No
   If no, sign below and return this document to requester.
   If yes, give the date the provider and the beneficiary signed the plan and proceed to next question. Date employment plan signed:

2. Is the beneficiary taking part in the activities and services outlined in the employment plan? ☐ Yes ☐ No
   If no, sign below and return this document to requester. If yes, please proceed to next question.

3. What is the employment goal?

4. Describe the education, work skills, and/or work experience that the beneficiary will acquire by completing the employment plan or by continuing to participate in the employment plan for a specified period of time.

5. When is the beneficiary expected to complete the activities and services outlined in the employment plan? (Month and Year) :

Signature: Date:

Title: Telephone No. (include area code): ( ) -

Section D - To be completed by an educational institution under the IDEA

1. Is the beneficiary's educational program provided under an Individualized Education Plan (IEP)? ☐ Yes ☐ No
   If no, complete Section C above.
   If yes, give the date the educational institution implemented the IEP and proceed to next question. Date IEP implemented:

2. Is the beneficiary taking part in the activities and services outlined in the IEP?
   ☐ Yes ☐ No
   If no, sign below and return this document to requester. If yes, please proceed to next question.

3. When is the beneficiary expected to complete the IEP? (Month and Year):

Signature: Date:

Title: Telephone No. (include area code): ( ) -

Privacy Act Statement

Public Law 106-170 and section 234 of the Social Security Act authorize the collection of information requested on this form. The information you provide will allow you or a beneficiary participating in the Ticket-to-Work and Self-Sufficiency Program to have more choices in receiving employment services. You do not have to give us this information. However, without this information, employment services, vocational rehabilitation services or other support services necessary for a participant to achieve a vocational goal may not be available to him or her.

The information you provide may be disclosed to another Federal, State, or local government agency for determining eligibility for a government benefit or program, to a Congressional office requesting information on your behalf, to an independent party for the performance of research and statistical activities, or to the Department of Justice for use in representing the Federal Government.

We may also use this information when we match records by computer. Matching programs compare our records with those of other Federal, State or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. The OMB control number for this form is 0960-0282. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments on our time estimate to this address, not the completed form.