SOCIAL SECURITY ADMINISTRATION

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 initial IEP implementation:
   Date current IEP implementation (if applicable):
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

Collection and Use of Personal Information

Development of Participation in a Vocational Rehabilitation or Similar Program, Form SSA-4290-F4.

Public Law 106-170 and section 234 of the Social Security Act, as amended (42 U.S.C. 434) authorize us to collect this information. 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. The information you provide on this form is voluntary. 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.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

See revised Privacy Act Statement below.

A complete list of routine uses for this inform ur Systems of Records Notice entitled, Completed Determination Record--Continuin tions, 60-0050; Claims Folder System, 60-0089; Vocational Rehabilitation Reimbursement Case Processing System, 60-0221; Electronic Disability (eDib) Claim File, 60-0320. These notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at 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, 6401 Security Boulevard, Baltimore, MD 21235. Send only comments on our time estimate to this address, not the completed form.