

## EN Services Certification Statement

|   |                                     |
|---|-------------------------------------|
| Employment Network Name:                    | DUNS Number:                        |
| Beneficiary Name:                           | Beneficiary Social Security Number: |
| Beneficiary Phone No:    Beneficiary Email: | Beneficiary Address:                |

When requesting any of the payments listed below, please fill-in Part 1 of this form concerning the provision of previously agreed upon services and Part 2 to indicate the services you will provide in the future. Keep a copy of this statement for your records.

|                       |            |
|-----------------------|------------|
| Phase I, Milestone 4  | Outcome 11 |
| Phase 2, Milestone 11 | Outcome 22 |

### Part I: Statement of Services Provided

Please check the last plan of services submitted for the beneficiary, and insert the date

Individual Work Plan (IWP)

IWP Addendum: Statement of Future Services

Continuing Employment Support Agreed to in IWP or IWP Addendum (Include dates of service):

Initial Services Agreed to in IWP (Include dates of service):

By signing below, the EN confirms that at least 50% of the agreed upon services have been provided to the beneficiary.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

|                               |      |
|-------------------------------|------|
| Beneficiary's Signature       | Date |
| EN Representative's Signature | Date |

**Part 2: IWP Addendum - Statement of Future Services**

Please list the future supports/services that you and the beneficiary agreed upon to help the beneficiary reach and sustain his or her long-term goal. Quarterly contact is a required service. If there are no other agreed upon services, please explain why.

**Description of Supports/Services:**

By signing below, the EN confirms that at least 50% of the agreed upon services have been provided to the beneficiary.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

|                               |      |
|-------------------------------|------|
| Beneficiary's Signature       | Date |
| EN Representative's Signature | Date |

## Privacy Act Statement Collection and Use of Personal Information

Section 1148, of the Social Security Act, as amended, authorizes us to collect this information. The information is needed to permit the Social Security Administration (SSA) to monitor the progress of a participant in the Ticket to Work and Self Sufficiency Program. The information you furnish on this form is voluntary. However, failure to provide all or part of the information requested on this form will prevent assignment of your Ticket to Work to your selected provider of services.

We rarely use the information you supply for any purpose other than for monitoring the progress of a participant in the Ticket to Work and Self Sufficiency Program. 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:

- (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 and Department of Veteran 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 and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0295 and 60-0300. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at [www.socialsecurity.gov](http://www.socialsecurity.gov) or at your local 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. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO: OPERATIONS SUPPORT MANAGER (OSM) TICKET TO WORK, Attn: Ticket Assignment, PO BOX 1433, ALEXANDRIA, VA 22313 OR FAX TO 703-893-4149.** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. Send only comments relating to our time estimate to this address, not the completed form.*