Development of Participation in a Vocational Rehabilitation or Similar Program

Part 1 - 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 1

10. Title	11. Date
12. DDS or FO Code	13. Telephone number (include area code)

Part 2 - To be completed by the 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 the State where services are provided, i.e., license, certification, accreditation, or registration.)
Section D - Educational Institution under IDEA

Section A - To be completed by Employment Network (EN)

1. Is the beneficiary receiving vocational rehabilitation services, employment services, or other support services under an Individual Work Plan (IWP)?

☐ Yes If yes, give the date the beneficiary and EN signed the IWP and proceed to next question.

Date IWP signed: _____

☐ No If no, sign below and return this document to requester.

2. Is the beneficiary taking part in the activities and services outlined in the IWP?

☐ Yes If yes, proceed to next question.

☐ No If no, sign below and return this document to requester.

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 number (include area code)

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

1. Is the beneficiary receiving VR services, employment services, or other support under an Individualized Plan for Employment (IPE)?

☐ Yes If yes, give the date the beneficiary and VR Counselor signed the IPE and proceed to next question.

Date IPE signed: _____

☐ No If no, sign below and return this document to requester.

2. Is the beneficiary taking part in the activities and services outlined in the IPE?

☐ Yes If yes, proceed to next question.

☐ No If no, sign below and return this document to requester.

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 number (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 If yes, give the date the provider and the beneficiary signed the plan and proceed to next question.

Date employment plan signed: _____

☐ No If no, sign below and return this document to requester

2. Is the beneficiary taking part in the activities and services outlined in the employment plan?

☐ Yes If yes, proceed to next question.

☐ No If no, sign below and return this document to requester.

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 number (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 If yes, give the date the educational institution implemented the IEP and proceed to next question

Date initial IEP implementation: _____

☐ No If no, complete Section C above.

2. Is the beneficiary taking part in the activities and services outlined in the IEP?

☐ Yes If yes, please proceed to next question.

☐ No If no, sign below and return this document to requester.

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

Signature	Date

Title	Telephone number (include area code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 225(b)(2) and 1631(a)(6) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from determining the beneficiary's continued eligibility for benefits.

We will use the information to determine if the beneficiary who is enrolled in a vocational rehabilitation or other job-training program is eligible to continue to receive benefits even if their disability has ceased. We may also share the information for the following purposes, called routine uses:

1. To Federal, State, or local agencies (or agents on their behalf) for administering cash or non-cash income maintenance or health maintenance programs (including programs under the Act); and,

2. To contractors or other Federal agencies, as necessary, for the purpose of assisting the Social Security Administration (SSA) in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORNs) 60-0050, entitled Completed Determination Record – Continuing Disability Determinations; 60-0089, entitled Claims Folders System; 60-0221, entitled Vocational Rehabilitation Reimbursement Case Processing System; and 60-0320, entitled Electronic Disability (eDib) Claim File. Additional information and a full listing of all our SORNs are available on our website at www.socialsecurity.gov/foia/bluebook.

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.*