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)

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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): ( ) _____ - _____