(Place on State Vocational Rehabilitation Agency Letterhead)

Date:

To:

From:

Subject: State Vocational Rehabilitation (VR) Agency Request for Medical Information
(VR Cost Reimbursement or Ticket to Work Program Purposes)

Beneficiary's Name: Beneficiary's SSN:

This is a Vocational Rehabilitation (VR) Cost Reimbursement or Ticket to Work program related request for medical information unavailable through my State's automated data exchange with the Social Security Administration. This request is for medical information on the beneficiary named above, free of charge, to assist us in determining this person's eligibility for the vocational rehabilitation and return to work services we provide.

I certify the following:

- The person identified in this request is eligible for my state's VR program because he or she is a Social Security Disability Insurance and/or Supplemental Security Income beneficiary based on blindness or disability; and

- I will use the medical information requested to determine the beneficiary's priority for service and plan the beneficiary's vocational rehabilitation and return to work.

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VR Agency Official's Signature Phone Number