

**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 <input type="checkbox"/> DI <input type="checkbox"/> SSI <input type="checkbox"/> 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): <input type="checkbox"/> <b>An Employment Network under an Individual Work Plan (IWP)</b> <input type="checkbox"/> <b>A State Vocational Rehabilitation agency under an Individualized Plan for Employment (IPE)</b> <input type="checkbox"/> <b>Other provider of services under an individualized, written employment plan similar to an IPE</b> <input type="checkbox"/> <b>An educational institution under an Individualized Education Program (IEP) to beneficiary age 18 through 21 years</b>		
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): ( ) -