REQUEST FOR CERTIFICATION OF SGA FOR VOCATIONAL REHABILITATION REIMBURSEMENT

Date

TO	FROM
ODO, MOD	Social Security Administration OD, DFDO, VRB P.O. Box 17287 Baltimore, MD 21235
DRS, PSC	
INT, PSC	
DO	

A VR agency has filed a claim for reimbursement of VR services that may have resulted in a VR continuous period of SGA. Please certify SGA per DI 13510.010 or DI 40520.150.

Name	SSN	VR Agency
VR Agency Reports Work Began *(mo./yr.)*	Employer	RRE's Name RRE's Phone *(Include Area Code)* FTS COMM.
Folder Location/Date	MBR/SSR ENT./ELIG. Status/Date	

ODO, DRS, INTPSC, DO CERTIFICATION

I. CERTIFICATION OF VR CONTINUOUS PERIOD OF SGA

☐ **A. Completed a VR continuous period of SGA**

1. Type of period → ☐ SGA in 9 consec. mos. ☐ SGA in 9 of 10 mos. ☐ SGA in 9 of 12 mos.

2. **SGA months** (Show first 9 mo. (mo./yr.) of SGA after current ent./elig. began) →	__ __	__ __	__ __	__ __	__ __	__ __	__ __	__ __	__ __
3. **Earnings** (Show earnings to correspond to SGA months above.) →									

☐ **B. Did not complete a VR continuous period of SGA**

1. SGA months (mo./yr. through mo./yr.) after current ent./elig. began
2. Reason work reported by VR agency not SGA
3. Performed SGA in 9 of 12 months but did not meet because *(Explain)*

☐ **C. Cannot determine whether a VR continuous period of SGA was completed**

☐ 1. Individual no longer on disability rolls and a VR continuous period cannot be established or ruled out from claims file alone.

☐ 2. Folder not available, current location _____ since _____

☐ 3. Other reason: _____

☐ **D. Remarks:**

II. DISABILITY STATUS

☐ Disability Continuing ☐ Disability Ceased (Show last mo./yr. ent./elig.)	Basis for Cessation ☐ Medical ☐ Other (Explain) _____	MIE or MIP DIARY Set ☐ Yes ☐ No

SIGNATURE REQUIRED ▶			Position
Office	Date	Phone No. *(Include Area Code)*	Return to: **SSA, OD, DFDO, VRB P.O. Box 17287 Baltimore, MD 21235**