BPAO Beneficiary/Recipient Form (OMB 0960-0629)

BPAO Program Identification Code: _____ **Benefit Specialist Code: _____**

Benefit Specialist Name: _____

Date of Intake (mm/dd/yyyy) **Date of Update** (mm/dd/yyyy) 11/4/2002

Demographic Information:

Last Name **First Name** **Middle Inital**

SSN - -

Address

Zip Code

Phone ( ) -

Date of Birth (mm/dd/yyyy) / /

Is the Date of Birth an Estimated Date? **Yes** **No**

1. Gender **Female** **Male**

2. Primary Disability at Intake

(1) Blind or Visual Impairment

- **(2) Hearing, Speech, and other Sensory Impairments**
- **(3) Spinal Cord Injury**
- **(4) Non-Spinal Cord Orthopedic Disabilities/Amputations/Motor Impairments**
- **(5) Mental and Emotional Disorders**
- **(6) Cognitive/Developmental Disabilities**
- **(7) System Diseases (e.g. nervous, endocrine, cardiac, etc.)**
- **(8) Traumatic Brain Injury**
- **(9) Infectious Disease**
- **(10) Injury**
- **(11) Cancer/Neoplasm**
- **(12) Other** (Must specify:)

3. Special Language or Other Considerations at Intake (Check all that apply)

- **Sign Language**
- **English as a Second Language**
- **Other**

4. Current Benefit(s) at Intake (Check all that apply)

- **SSI**
- **SSDI**
- **Concurrent SSI/SSDI**

- [ ] **Medicare**
- [ ] **Medicaid**
- [ ] **Private Health Insurance**
- [ ] **Subsidized Housing**
- [ ] **Food Stamps**
- [ ] **TANF**
- [ ] **Workers Compensation**
- [ ] **Unemployment Insurance**
- [ ] **Veterans Benefit**
- [ ] **Other**

5. Current Employment Status at Intake

- ( ) **(1) Employed Full-Time**
- ( ) **(2) Employed Part-Time**
- ( ) **(3) Not Employed, Seeking Employment**
- ( ) **(4) Not Employed, Not Seeking Employment**

Service Related Questions:

6. Reason for service request (Check all that apply)

- [ ] **Responded to outreach from BPAO program**
- [ ] **Communication from SSA**

☐ **Responded to Ticket to Work Communication from SSA**

☐ **Not working, but considering going to work**

☐ **Working, and considering/anticipating change in employment status**

☐ **Contacted Program as a result of actual change experienced in employment status**

○ **(1) lost job** ○ **(2) starting new job** ○ **(3) increase/decrease in salary**

☐ **Anticipated or actual change experienced in other financial or life factors (including other benefits, health care coverage, living arrangement, marital status...)**

☐ **Other** _____

7. Service(s) delivered (Check all that apply)

☐ **Information and Referral**

☐ **Problem Solving and Advocacy**

☐ **Benefits Analysis and Advisement**

☐ **Benefits Support Planning**

☐ **Benefits Management**

8. Recommended Incentives to be Used (Check all that apply)

☐ **TWP**

☐ **EPE**

☐ **PASS**

☐ **IRWE**

- [ ] **1619 (a)**
- [ ] **1619 (b)**
- [ ] **Medicaid Buy-In**
- [ ] **Blind Work Expense**
- [ ] **Student Earned Income Exclusion**
- [ ] **Subsidy Development**
- [ ] **Extended Medicare**

9. Recommended Provisions to be Used (Check all that apply)

- [ ] **Property Essential to Self Support**
- [ ] **Expedited Reinstatement of Benefits**
- [ ] **Ticket to Work Program**
- [ ] **Continuing Disability Review (CDR) Protections**
- [ ] **Section 301**
- [ ] **Unsuccessful Work Attempt**

10. Anticipated Employment Status Change

- ○ **(1) Does not intend to change current employment status**
- ○ **(2) Intends to seek new job or supplemental job**
- ○ **(3) Intends to increase work hours in current job**
- ○ **(4) Intends to decrease work hours in current job**

○ **(5) Intends to cease employment**

○ **(6) Made no decision**

10a. ☐ **Intends to use Ticket to Work to seek new or supplemental job (check if Yes)**

10b. ☐ **Intends to pursue education or training (check if Yes)**

11. What is the approximate TOTAL amount of time spent working with or for the participant thus far

○ **(1) Less than 1 hour**

○ **(2) One hour or more (Specify TOTAL in whole hours:)**

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