
WIPA Beneficiary/Recipient Application (OMB No. 0960-0629)

WIPA Program Identification Code: _____ Benefit Specialist Code:

Community Work Incentives Coordinator Name:

Date of Intake (mm/dd/yyyy)

Date of Update (mm/dd/yyyy)

11/4/2002

Demographic Information:

Last Name

First Name

Middle Initial

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 WIPA 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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