

Ticket To Work Individual Work Plan

Beneficiary:	SSN:
Address:	Telephone:
	Email:
Employment Network Name:	EIN#:
Address:	Telephone:
	Email:

1. **What Is Your Specific Vocational Goal And Expected Monthly Earnings Amount?**

Short Term Goal (in the next 3 to 12 mos.):

Expected Monthly Earnings Amount (in the next 3 to 12 mos.):

Long Term Career Goal (throughout the next 5 years):

Expected Monthly Earnings Amount (throughout the next 5 years):

2. **What Supports/Services Have You and Your Counselor Agreed Would be Required for You to Reach Your Short Term Goal?**

During the job search phase and the first nine months of employment:

After your first 9 months on the job (job retention supports and career advancement, if any):

3. **Work History**

Please check all that apply:

- I had no earnings in the last 18 months.
- I had some earnings in the last 18 months.
- None of my earnings were in the last 6 months.
- Some of my earnings were in the last 6 months. (Please describe those earnings in the chart below, listing your most recent employer first.)

Employer	Start Date	End Date	Wage Per Hour	Hours Worked Per Week

NOTE to EN: As a convenience, you may attach a completed 18-Month Prior Earnings Worksheet (available at http://www.yourtickettowork.com/training_2) or just use it for your own information.

4. **Terms and Conditions Related to the Provision of Services**

(If there are no terms and conditions, then that must be stated)

CONSUMER RIGHTS & REMEDIES (Insert EN name in the blanks below, unless otherwise stated)

As a consumer of _____ you have the following rights:

- 1) _____ may not request or accept any compensation from you for the costs of services and supports we provide you.
- 2) This IWP may be amended by you or _____ if both parties agree.
- 3) _____ may end this relationship if no longer able or willing to provide services as planned.
- 4) You may unassign your Ticket at any time if you are dissatisfied with the services and supports being provided by _____.
- 5) If you and _____ are unable to resolve any disputes about the services and supports being provided, the internal dispute resolution process will be available to you. You may also contact the State Protection and Advocacy Program for assistance.
- 6) _____ has informed you the beneficiary of the annual progress reviews and the Timely Progress Review guidelines.
- 7) Your personal information including your Social Security number and information about your disability will be kept private and confidential.
- 8) Only qualified employees and/or providers will be used to furnish services.
- 9) If any medical or related health services are provided, they will be provided under the supervision of persons licensed to prescribe or supervise the provision of these services in the State in which the services are performed.
- 10) A copy of this IWP will be provided to you in an accessible format.

I declare under penalty of perjury that I have examined all the information on the form and any accompanying statements or forms, and it is true and correct to the best of my knowledge.

By signing below, I agree to the terms of this IWP and give my permission to _____ to contact employers on my behalf to verify or obtain evidence of work or earnings.

Beneficiary's Signature:

EN Representative's Signature:

Date:

Date:

Privacy Act Statement

Collection and Use of Personal Information

Section 1148, of the Social Security Act, as amended, authorizes us to collect this information. The information is needed to permit the Social Security Administration (SSA) to document the requirements towards achieving your employment goal under the Ticket to Work Program. The information you furnish on this form is voluntary. However, failure to provide all or part of the information requested on this form will prevent you from pursuing your employment goal under the Ticket to Work program.

We rarely use the information you supply for any purpose other than documenting the requirements towards achieving your employment goal under the Ticket to Work program. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to: (1) to enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veteran Affairs); (3) to make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; (4) to State agencies or Employment Networks having an approved business arrangement with SSA to perform vocational rehabilitation services for disability beneficiaries and recipients; and (5) to facilitate statistical research, audit or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, state or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for Federally funded and administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Record Notices 60-0295 and 60-0300. The notices, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions. **SEND THE COMPLETED FORM TO MAXIMUS TICKET TO WORK, PO BOX 1433, ALEXANDRIA, VA 22313, OR FAX TO 703-683-3289..** You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401. **Send only comments relating to our time estimate to this address, not the completed form.**