
INDIVIDUAL WORK PLAN (IWP)

Statement of Understanding

I choose to participate in the Ticket To Work Program with the Employment Network (EN) named below. I understand that my EN will provide me with employment support to find and keep a job, increase my earnings or run my own business. If possible, I plan to increase my earnings to support myself. I understand that I can change this plan with my EN from time to time to meet my current needs

Employment Network Name:

DUNS:

Address:

Telephone:

Email:

My Name:

SSN:

Address:

Telephone:

Email:

Alternate Contact's Name:

Telephone:

Address:

Email:

Alternate Contact's Name:

Telephone:

Address:

Email:

Alternate Contact's Name:

Telephone:

Address:

Email:

Part One: My Vocational Goal and Expected Monthly Earnings

Short Term Vocational Goal (in the next 3-12 months):

Expected Monthly Earnings (in the next 3-12 months):

Long Term Vocational Goal (in the next 3-5 years):

Expected Monthly Earnings (in the next 3-5 years):

Part Two: The Supports and Services the EN Agreed to Provide to Help Me Reach My Vocational Goal

My EN and I have agreed upon the supports/services checked or written below; Below we also explain the steps the two of us agreed to take to help me reach my vocational goal. This includes any referrals my EN agreed to make to help me get services.

- Career counseling and guidance (at a minimum, required during IWP development)

Note: On the last page, EN must certify to providing career counseling.

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- Job search or placement services (required, if not working)

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- Job coaching/training

-
-
- Job accommodation planning

Part Two (con't)

Continuing employment supports (required quarterly, contact by EN to assess needs).

Other (Please explain below)

Part Three: My Recent Work History

Check all that apply

- I am currently working.
- 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.

If you had earnings in the last 6 to 18 months, please describe those earnings in the following chart. List your latest employer first.

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

Part Four: Conditions Related to the Success of my IWP

- I will inform my EN of changes in my contact information
- My EN will contact me as needed to share information and determine any unmet needs (at least quarterly).
- I will inform my EN of my earnings.
- While I am working, my EN will offer and provide me with ongoing employment support to help me keep working or refer me to others who can help me keep working.

My EN and I have agreed to the other conditions described below.
(If there are no other conditions, please state "no other conditions").

I understand that I have the following rights under the Ticket to Work Program.

As my EN, _____, you:

- 1) **May not request or accept any compensation from me for the costs of service sand supports provided to me as an EN.**
- 2) May change this IWP, as long as we both agree. Any change to this IWP must be made in writing.
- 3) Will provide or help me to obtain ongoing employment support, as necessary,designed to help me keep my job.
- 4) May unassign my Ticket at any time if either of us are not satisfied for any reason.
- 5) Explained its internal resolution process. If we are unable to resolve a dispute,another process is available to me through the Ticket Call Center at 1-866-968-7842.
- 6) Provided me with the phone number of the State Protection and Advocacy Program where I can receive free services. The phone number is:
- 7) Informed me of the annual progress reviews and the Timely Progress Review guidelines.
- 8) Will keep my personal information, including my Social Security number and information about my disability, private, and confidential.
- 9) Will use only qualified employees and/or providers to provide services to me.
- 10) Will provide me with a copy of this IWP and any changes in an accessible format.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

By signing below, you as the EN agree to repay any payments received (or allow the amount to be deducted from future payments) if it is determined at a later date that you were not entitled to payment.

Beneficiary's Signature: _____ Date: _____

EN Representative's Signature: _____ Date: _____

FOR EN COMPLETION

(Record of Career Counseling Provided During IWP Development)

Name of
Counselor:

Date:

Duration:

Name of
Counselor:

Date:

Duration:

Collection and Use of Personal Information Privacy Act Statement

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 verify eligibility for payment. The information you furnish on this form is voluntary. However, failure to provide all or part of the information requested on this form could prevent you from receiving payment.

We rarely use the information you supply for any purpose other than verifying eligibility for payment. 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 a 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 XX 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.*