

18. If any household member (spouse or children) receives any type of means-tested benefits describe:

19. For SSI and Medicaid recipients only, describe all income or in-kind support received including source and amount of income:

20. Does the beneficiary have a My Social Security account? Yes No Recommended

21. Primary contact information:

Beneficiary Representative Payee Guardian Other (specify) _____

22. Address (include city, state, and ZIP):

23. Phone	a. Home:	
	b. Cell:	c. Work:
	d. TTY/Videophone Number/IP address:	

24. Email address:

25. Best time to reach:

26. Preferred manner of contact:

Telephone Email In-Person Skype or Other Video Conferencing
 Via an Interpreter Other (specify) _____

27. Benefits Summary and Analysis (BS&A) delivery:

Telephone Email In-Person Skype or Other Video Conferencing
 Via an Interpreter Other (specify) _____

28. Describe language or accommodation needs:

29. Alternate contact information:

Beneficiary Representative Payee Guardian Other (specify) _____

30. Address (include city, state, and ZIP):

31. Phone	a. Home:	
	b. Cell:	c. Work:
	d. TTY/Videophone Number/IP address:	

32. Email address:

33. Best time to reach:

34. Preferred manner of contact:

Telephone Email In-Person Skype or Other Video Conferencing
 Via an Interpreter Other (specify) _____

35. Please describe any language or accommodation needs:

Educational History and Goals

36. Highest grade completed:

Primary or Secondary school Certificate Graduate Equivalent (GED) High School
 Vocational/Technical Some college Undergrad Graduate Degree

37. Describe any educational goal(s):

Employment history and financial goals:

38. Does the beneficiary want to eliminate benefits? Yes No

39. Does the beneficiary want to reduce dependence on benefits? Yes No

Employment goal(s):

40. Earning goal 1:

- a. Type of position or field of work: _____
- b. Number of hours anticipated per week: _____
- c. Hourly wage or salary: _____
- d. Estimated monthly earning goal: _____

41. Earning goal 2:

- a. Type of position or field of work: _____
- b. Number of hours anticipated per week: _____
- c. Hourly wage or salary: _____
- d. Estimated monthly earning goal: _____

42. Please list the employment services the beneficiary receives:

Agency	Service	Service	Service
Employment Network			
State VR			
Other Employment Services			
American Job Center			
Vocational Training			
Youth Transition Program			
Other (specify below):			

43. List the services the beneficiary needs to reach his or her employment goal:

44. Does the beneficiary want you to share the BS&A or other information about benefits advisement with any employment support agency or other person? If yes, obtain release. Yes No

Employment Since Entitlement

45. Is the beneficiary currently employed or self-employed? Yes No

a. If "Yes," list the name of the beneficiary's Employer or beneficiary business

b. The beneficiary is employed self-employed

c. The employment or self-employment is full-time part-time

d. If employed, the amount of gross wages every hour week month year is _____

e. If employed, what weekday or dates does the employer issue the paycheck? _____

f. If the beneficiary is self-employed, what is the nature of the business:

g. What is the beneficiary's estimated net profit? _____

h. Has the beneficiary reported these earnings to Social Security? Yes No

i. If "Yes," give the date(s) of the report, and the manner he or she used to report the earnings:

Benefits at intake

46. SSA Benefits:

Benefit	Receiving	Comments
SSI	<input type="checkbox"/>	<input type="checkbox"/>
SSDI	<input type="checkbox"/>	<input type="checkbox"/>
CDB	<input type="checkbox"/>	<input type="checkbox"/>
DWB	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

47. Medicaid:

Benefit	Receiving	Recommended
SSI-based	<input type="checkbox"/>	<input type="checkbox"/>
1619(b)	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Home and Community-based Waiver (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Spend-down	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid Buy-in	<input type="checkbox"/>	<input type="checkbox"/>
Other Medicaid Program	<input type="checkbox"/>	<input type="checkbox"/>

48. Medicare:

Benefit	Receiving	Recommended
Part A	<input type="checkbox"/>	<input type="checkbox"/>
Part B	<input type="checkbox"/>	<input type="checkbox"/>
Medicare Savings Program (QMB/SLMB/QI1) or other Medicare Buy-in group	<input type="checkbox"/>	<input type="checkbox"/>
Part D	<input type="checkbox"/>	<input type="checkbox"/>
Part D Low Income Subsidy	<input type="checkbox"/>	<input type="checkbox"/>
Premium HI for Working Disabled	<input type="checkbox"/>	<input type="checkbox"/>

49. Other Benefits:

Benefit	Receiving	Recommended
Employer or other Private Health Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Food Stamps (SNAP)	<input type="checkbox"/>	<input type="checkbox"/>
Housing Subsidy (Specify type)	<input type="checkbox"/>	<input type="checkbox"/>
Veteran's Compensation	<input type="checkbox"/>	<input type="checkbox"/>

Benefit	Receiving	Recommended
Veteran's Pension	<input type="checkbox"/>	<input type="checkbox"/>
TANF	<input type="checkbox"/>	<input type="checkbox"/>
Unemployment Insurance	<input type="checkbox"/>	<input type="checkbox"/>
Worker's Compensation	<input type="checkbox"/>	<input type="checkbox"/>
Public Disability Benefit	<input type="checkbox"/>	<input type="checkbox"/>
Alimony or child support (specify)	<input type="checkbox"/>	<input type="checkbox"/>
Energy Assistance	<input type="checkbox"/>	<input type="checkbox"/>
SSI State Supplementation	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify)	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

50. Excluded Savings

Benefit	Receiving	Recommended
Individual Development Account (IDA)	<input type="checkbox"/>	<input type="checkbox"/>
ABLE account	<input type="checkbox"/>	<input type="checkbox"/>
Trust	<input type="checkbox"/>	<input type="checkbox"/>

51. Additional Benefits (For example, benefits specific to your state)

Benefit	Comments

52. List out of pocket expenses that could be Impairment Related Work Expenses (IRWE) or Blind Work Expenses (BWE):

53. Describe special employment supports the beneficiary received in the past, currently uses, or expects to need in the near future. Also describe any other indication that the beneficiary has a possible subsidy, such as working with a job coach.

54. Notes, additional information and next steps:

SSA will insert the following revised Privacy Act Statement into the form as soon as possible:

**Privacy Act Statement
Collection and Use of Personal Information**

Sections 1148 and 1149 of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may limit your ability to participate in the Work Incentive Planning and Assistance (WIPA) program.

We will use the information you provide to determine if you qualify for the WIPA program. We may also share your information for the following purposes, called routine uses:

- To State or Employment Networks having an approved business arrangement with Social Security Administration (SSA) to perform vocational rehabilitation services for SSA disability beneficiaries and recipients; and
- To contractors and other Federal agencies, as necessary, for the purpose of assisting SSA in the efficient administration of its programs.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0295, entitled Ticket-to-Work and Self-Sufficiency Program Payment Database, as published in the Federal Register (FR) on April 4, 2001, at 66 FR 17985, and 60-0300, entitled Ticket-to-Work Program Manager Management Information System, as published in the FR on June 15, 2001, at 66 FR 32656. Additional information, and a full listing of all of our SORNs, is available on our website at www.ssa.gov/privacy.

SSA will insert the following revised PRA Statement into the form as soon as possible:

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 (OMB) control number. We estimate that it will take about 20 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.***